Medicare Contractor Beneficiary and Provider Communications Manual

Chapter 6 - Provider Customer Service Program

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(Rev. 15, 11-18-05)

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Provider Customer Service Program

NOTE: Those contractors funded for the requirements in CR 3376 shall follow the instructions in this chapter. Contractors not funded for CR 3376 shall follow the instructions in Chapters 3 and 4 of IOM Pub. 100-09.

10 – Introduction

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

CMS requires that all Medicare contractors have a quality Provider Customer Service Program (PCSP) and tools in place to assist providers in understanding and complying with Medicare's operational processes, policies, and billing procedures that are governed by Federal law and regulation. The PCSP serves to strengthen and enhance Medicare's ongoing efforts associated with provider inquiries and education. The primary principle is to continuously improve Medicare customer satisfaction through the timely delivery of accurate, accessible, and consistent information to providers in a courteous and professional manner. These practices will enable providers to understand, manage, and bill the Medicare program correctly.

The PCSP integrates provider inquiry and provider education contractor activities creating a comprehensive program. The PCSP shall be a trusted source of accurate and relevant information, staffed with personnel that have technical and customer service expertise and experience to address various provider inquiries and to develop and deliver provider education. The PCSP consists of three major components: Provider Outreach and Education (POE), Provider Contact Center (PCC), and Provider Self-Service Technology (PSS).

Contractors shall develop and implement, wherever practicable, performance standards that measure the effectiveness of each specific component under the PCSP. The results of the performance metrics shall be used to modify the contractor's PCSP in response to identified needs. This includes, but is not limited to, customer satisfaction survey instruments, pre- and post-testing at workshops and seminars, and other measurable feedback mechanisms. In addition, the CMS views the PCSP as a flexible program that shall identify and respond to issues, needs, and vulnerabilities at the earliest possible opportunity.

It is imperative that contractors coordinate with other internal components to resolve issues as quickly as possible, and consult with their RO and Central Office (CO) contacts in resolving these issues. In addition, contractors are strongly encouraged to maintain complete documentation of the progress and performance of their PCSP.

20 – Provider Outreach and Education (POE)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Providers require information about various Medicare programmatic, billing, and claims issues in order to manage Medicare-related matters on a daily basis. Therefore, Medicare contractors shall develop strategies that offer Medicare providers a broad spectrum of information about the Medicare program (including billing the Medicare program appropriately), as well as reducing the number of provider inquiries and claims errors, through a variety of communication

channels. At a minimum, strategies shall address basic Medicare topics, as well as the specific topics and subject areas identified later, as priorities for provider education. The CMS encourages contractors to be innovative and persistent in their identification of priorities and provider educational needs. Well-informed providers are more likely to bill correctly, thereby reducing the error rate.

20.1 - POE Strategies and Activities

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall utilize a variety of strategies and methods for the dissemination of information to providers -- including print, Internet, satellite networks, and other technologies, face-to-face instruction, and presentations in classrooms and other settings -- to meet the needs of Medicare providers for timely, accurate, and understandable Medicare information. Unlike the Local Provider Education and Training (LPET) program, which is geared to reducing the claims payment error rate by being responsive to individual provider's claim submission patterns, these strategies shall be designed to be broad in nature so as to meet the basic informational needs of Medicare providers as a group.

POE activities shall be described in the annual Provider/Supplier Service Plan (PSP) as well as reported on the Quarterly Activity Reports (QARs) See § 20.3.1 and § 20.3.2 for more information about the PSP and QAR. The following are the strategies and activities contractors will utilize and maintain in their POE efforts:

20.1.1 - Inquiry Analysis

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

For provider inquiry analysis, contractors shall maintain a systematic and reproducible provider inquiry analysis program that will produce a monthly list of the most frequently asked questions (FAQs) beyond claims status and eligibility and areas of concern/confusion for providers. This process shall be described in the PSP. Contractors shall utilize information or instructions furnished by CMS to classify or categorize provider inquiries. (See § 30.1) Educational efforts shall be developed and implemented to address the needs of providers as identified by this program.

20.1.2 – Claims Submission Error Analysis

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall maintain a provider data analysis program that will produce a monthly list of the most frequent collective claims submission errors from all providers in their jurisdiction. Claims submission errors are those that result in rejected, denied, or incorrectly paid claims. This information shall be utilized to develop and modify the topics the contractor's POE strategy addresses.

20.1.3 - POE Advisory Groups

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The primary function of the Advisory Group is to assist the contractor in the creation, implementation, and review of provider education strategies and efforts. The Advisory Group provides input and feedback on training topics, provider/supplier education materials, and dates and locations of provider education workshops and events. The group also identifies salient provider education issues, and recommends effective means of information dissemination to all appropriate providers and their staff. The Advisory Group shall be used as a provider education consultant resource, and not as an approval or sanctioning authority.

The contractor shall maintain the Advisory Group. It is not permissible for the contractor to allow outside organizations to operate the Advisory Group. After soliciting suggestions from the provider community, the contractor shall select the appropriate individuals and organizations to be included in the group. The main point of contact for all POE Advisory Group communication shall be within the contractor's provider outreach and education area or similar department. At a minimum, the contractor is responsible for recruiting potential members, setting-up and arranging all meetings, handling meeting logistics, producing and distributing an agenda, completing and distributing minutes, and keeping adequate records of the advisory group's proceedings.

POE Advisory Groups operate independently from other existing contractor advisory committees. However, while Advisory Group members can be members of other advisory committees, the majority of group members shall not be current members of any other contractor advisory group. Contractors shall strive to maintain professional and geographic diversity within the Advisory Group(s) and have representatives of the major provider specialties or provider institutions they serve. Providers from different geographic areas, as well as from urban and rural locales, shall be represented in the Advisory Group.

Contractors shall consider having more than one POE Advisory Group when the breadth of its geographic service area, or range of the providers serviced, diminishes the practicality and effectiveness of having a single Advisory Group.

Medicare contractors shall have separate advisory groups for each kind of Medicare contract (e.g., intermediary, Part B carrier, regional home health intermediary, Medicare Administrative Contractors). It is also impermissible for contractors having geographic proximity or overlap with one another to share an Advisory Group. Each contractor shall have its own separate group.

The Advisory Group shall generally convene quarterly, but at a minimum, shall meet three times per year. Contractors may hold Advisory Groups in-person or via teleconferencing. The CMS recommends that, if possible, contractors hold at least one in-person meeting per calendar year. Teleconferencing or other technological methods shall be available for Advisory Group members who cannot be physically present for any meeting.

Contractors shall not reimburse or charge a fee to group members for membership or for costs associated with serving on an Advisory Group. Contractors shall have a specific area on their

Web site that allows providers to access information about the Advisory Group. This information shall include minutes from meetings, upcoming meetings dates and locations, list of organizations or entities comprising the Advisory Group, an e-mail address for a contact point for further information on the Advisory Group, etc.

Contractors shall consider the suggestions and recommendations of the Advisory Group, and implement those deemed feasible, practicable, and in the best interest of an effective PCSP. In the interest of maintaining a working relationship, the contractor shall explain to the group reasons for not implementing or adopting any group suggestions or recommendations.

Meeting agendas, which include discussion topics garnered from solicitation of group members, shall be distributed to all members of the group and the CMS regional office POE coordinator prior to any meeting. After each meeting, minutes shall be disseminated within a reasonable time to all group members and others who request them.

Contractors shall use their Advisory Group(s) to assist in establishing the timing, frequency, size, topics, and provider type(s) to be included in Ask the Contractor Teleconferences.

20.1.4 - "Ask-the-Contractor" Teleconferences (ACT)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

"Ask-the-Contractor" Teleconferences provide a means for providers to ask their contractors specific questions concerning billing, Medicare policies or procedures. They are not to be confused with the functions of the POE Advisory Group which provides input and feedback to the contractor on provider education strategies and efforts.

Contractors shall organize toll-free "Ask-the-Contractor" Teleconferences (ACT) to complement, but not replace, the work of the Advisory Group(s). Due to the explicit nature of the subjects covered, ACTs serve to identify provider issues and problems in a clear and timely manner. They also provide a method of sharing information, and function as a tool for listening to the contractor's provider community. Contractors shall offer ACTs at least quarterly. In designing ACTs, contractors shall consider other technological approaches, such as web-chat capabilities. Contractors shall also invite CMS Regional Office staff to participate in ACTs.

20.1.5 - Provider Bulletins/Newsletters

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

At least quarterly, contractors shall produce, print and distribute to their provider community a provider bulletin/newsletter and post it on its provider website. These bulletins/newsletters shall contain Medicare program and billing information, and be structured in such a way that information can be easily pinpointed according to its provider specialty/interest focus. In addition, printed bulletins shall have a notation in boldface type that states the following: "This Bulletin Shall Be Shared with All Health Care Practitioners and Managerial Members of your

Provider Staff. Bulletins Are Available at No Cost from Our Web Site [Insert Web Site Address]."

Contractors may use alternative distribution methods to printing and mailing paper bulletins. Contractors that have been approved by CMS for alternative distribution of bulletin information by December 31, 2005, shall continue to distribute their bulletins/newsletters in the manner that was approved. After December 31, 2005, both existing and new contractors interested in alternative distribution methods shall develop a proposal and submit it to CMS for approval. For a complete list of proposal requirements, go to www.cms.hhs.gov/contractors. Some elements of a proposal shall include:

1. Alternative distribution method, i.e. contractor website, CD-ROM;
2. Documentation that electronic bulletins will contain the same information as paper bulletins;
3. Projected savings over paper distribution (hours and/or dollars),and
4. Plans for use of projected savings.

Contractors shall submit an evaluation of their alternative distribution method six months from its implementation date. A second evaluation is due six months from the first evaluation. Evaluations shall include:

1. Estimated savings during six months;
2. Total number of paper bulletins distributed during six months;
3. Analysis of why paper bulletins were requested by providers/suppliers, and suggestions of ways to assist them in getting electronic bulletins;
4. Total number of providers/suppliers who are receiving paper bulletins after six months, and
5. Total number of provider/supplier praises and complaints along with a description of praises and complaints.

Contractors shall submit all evaluations electronically to CMS Central Office (CO) at ProviderServices@cms.hhs.gov .

After implementation, contractors may choose to modify elements of their alternative distribution program. Prior to implementing changes, contractors shall first submit proposed modifications to CMS for approval. Proposals containing modifications shall be submitted to ProviderServices@cms.hhs.gov. Contractors shall submit additional evaluation of their alternative distribution program six months after CMS has approved any modification(s)

20.1.6 - Education and Training Events

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall educate and train providers and their staffs by holding various learning events such as workshops, seminars, classes, other face-to-face meetings, teleconferences, Web casting, Web-based and computer-based trainings, and other technologically-oriented meetings. These

events shall be designed to support the contractor's priorities and strategies regarding the Medicare program and billing Medicare.

Contractors shall routinely and directly notify external groups, organizations, and other interested entities within their geographic service area of upcoming provider education and training events. Direct notification avenues include mail, telephone, and e-mail. Notifications shall be made sufficiently in advance of scheduled events to allow for any registration requirements.

20.1.7 - Training for New Medicare Providers

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall conduct at least two events in person during the year that are tailored to the needs of new Medicare providers and billing staff. These workshops shall deal with fundamental Medicare policies, programs, and procedures and shall concentrate and feature information on the billing of Medicare.

20.1.8 - Training Tailored for Small Providers

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Medicare contractors shall tailor education to small providers. Small providers are defined by law as providers with fewer than 25 full time equivalents or suppliers with fewer than 10 full time equivalents. Contractors shall not be required to identify or validate providers meeting the definition of small provider.

Contractors shall offer at least one event containing information tailored to the needs of small providers per quarter, with a minimum total of 6 events per state serviced per fiscal year. These educational events shall involve interactive communication such as occurs in face-to-face trainings and in certain web-based tutorials or instruction. Web-based events that allow participation from providers in multiple states count toward the minimum number of events per state as long as the event was promoted in that state.

Education and training of small providers may include the provision of technical assistance, such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance. Small provider technical assistance can also include educational seminars for groups of providers identified as having similar problems with their billing systems or internal controls. It also can include assistance from EDI support staff, since much of the billing system technical expertise at the contractor resides with that staff.

20.1.9 – Provider Information and Education Materials

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall, as needed, develop and disseminate provider information and education materials that support their training events, as well as their overall PCSP strategies. Contractors shall ensure that all materials are written in a manner that is clear, concise, and accurate. POE materials produced shall bear the month and year they were produced or re-issued. These

materials shall be made available, whenever practicable, in both electronic and print formats, and be disseminated in a format and means that are timely, efficient, and cost-effective.

All materials developed by Medicare contractors using CMS funding as the principal source for its development are considered the property of CMS, and shall be made available to CMS upon request. If a contractor reproduces or uses material, in whole or in part, originally developed by another Medicare contractor, that contractor shall be acknowledged either within the material, or on its cover, case or container.

As needed, contractors shall develop and produce provider education products that use special media, (videos, web/computer based training courses, audio tapes, CD ROMs, etc) to support their POE efforts.

20.1.10 - Partnering with External Entities

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall work toward establishing partnerships with external entities to help disseminate Medicare provider/supplier information. Whenever feasible, events and activities shall be coordinated with other Medicare contractors and entities, including quality improvement organizations (QIOs), State Health Insurance Assistance Programs (SHIPs), and End Stage Renal Disease (ESRD) networks as well as interested groups, organizations, and CMS partners. In addition, contractors shall routinely and directly notify other interested entities of their upcoming events and activities.

Partnering entities may be medical, professional or trade groups and associations, government organizations, educational institutions, trade and professional publications, specialty societies, and other interested or affected groups. By establishing collaborative information dissemination efforts, provider/suppliers will be able to obtain Medicare program information through a variety of sources. Partnering or collaborative provider information and education efforts can include:

1. Printing information in member newsletters or publications;
2. Reprinting and distributing (free-of-charge) provider/supplier education materials;
3. Giving out provider/supplier education materials at organization meetings and functions;
4. Scheduling presentations or classes to or for members;
5. Posting provide/supplier information on organization's websites; and,
6. Helping organizations develop their own Medicare provider/supplier education and training material.

Partnership activities shall not take the place of contractor-led POE events but shall supplement them.

20.1.11 - Remittance Advice Messaging

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

When a provider elects to receive the Standard Paper Remittance (SPR), contractors shall use the SPR provider messaging properties, when available, of this notice to convey Medicare programmatic information including, but not limited to, the promotion of their Medicare provider Web site, changes in policies and programs, and the promotion of their upcoming POE activities and efforts.

20.1.12 - Internal Development of Provider Issues

(***(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)***

Contractors shall coordinate internally with staff in appropriate areas (including personnel responsible for medical review, enrollment, EDI/systems, appeals, and program integrity) to ensure that provider inquiries and issues identified by these other areas in the organization are communicated and shared with the POE staff. At a minimum, periodic meetings shall be held with these various components to discuss any provider issues and potential mechanisms to resolve them. Documentation of these meetings and activities shall be retained by the contractor.

20.1.13 - Training of Provider Education Staff

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall implement a developmental plan for training new provider education personnel, and periodically assess the training needs of existing education staff. The plan, which shall be written and available to the education staff, shall include schedules, course or instruction vehicle descriptions, and satisfaction criteria. Training materials such as workbooks, manuals, and policy guidelines shall always be readily available to the education staff.

20.2 - Medicare Educational Topics

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall, at a minimum, provide all the necessary information and cover all the subjects needed in their POE activities to enable providers to understand the Medicare program and its policies and how to bill Medicare appropriately. Contractors shall provide basic Medicare programmatic and billing information and education to Medicare providers throughout the year to keep them abreast of fundamental Medicare policies, programs, and procedures, including information about new Medicare programs, policies, initiatives, and significant changes to the Medicare program. This information shall include material providers, and their staffs, need in order to administer and bill the Medicare program appropriately.

20.2.1 –Error Rate Reduction

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Medicare contractors shall use error rate information and other relevant data sources to design appropriate provider education. Contractors shall evaluate and analyze all of their error rate data, including the CERT Provider Compliance Error Rate. Using data analysis, the contractor shall design and implement a provider education methodology that leads to a reduction in the claims error rate. The education activities shall focus on those areas of the error rate that represent high dollar impact to the Medicare program. The Error Rate Reduction Plan (ERRP), required by PIM 12.3.9, shall identify provider education activities. Contractors shall also describe in their ERRPs internal systems and strategies to address identified errors as well as innovative education and training that will be implemented to reduce these errors. CMS will be reviewing the ERRPs and the error rate data to ensure that contractors are effectively implementing targeted provider education under this requirement.

20.2.2 - Electronic Claims Submissions

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall conduct training for providers or their staff in electronic claims submission. The contractor shall conduct training activities for providers to educate them on and expand their use of Medicare billing software and the electronic data interchange transactions supported by Medicare.

20.2.3 - Medicare Preventive Service Benefits

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall conduct POE activities that promote the use of preventive services and other benefits provided by the Medicare program to beneficiaries as appropriate for the contractor's provider community. These preventive services may include, but are not limited to, initial physical examinations, cardiovascular and diabetes screening tests, screening mammographies, and screenings for colorectal, cervical, and prostate cancer. Other benefits include, but are not limited to, such topics as newly covered services and new or modified payment systems.

20.2.4 - Remittance Advice Notices

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Providers receive a remittance advice, which is a notice of payment and adjustment, once a claim has been received and processed. An adjustment refers to any change that relates to how a claim is paid differently from the original billing. Adjustments can include denied claim, zero payment, partial payment, reduced payment, penalty applied, additional payment and supplemental payment. Two important non-medical code sets are used to communicate an adjustment, or why a claim (or service line) was paid differently than it was billed. These code sets are Claim Adjustment Reason Codes and Remittance Advice Remark Codes. Descriptions for both of these code sets appear at: www.wpc-edi.com/servicesreview.asp.

Contractors shall promote the use and understanding of the Remittance Advice as an educational tool for communicating claims payment information. Whereas specific instruction has not been giving by CMS to use specific Claim Adjustment Reason Codes and Remittance Advice Remark Codes to communicate claim payment and adjustment information and a code would help reduce provider inquiries, contractors shall use appropriate codes. Contractor provider inquiry, provider outreach and education and system staff shall work together to identify Claim Adjustment Reason Codes and Remittance Advice Remark Codes to help communicate an adjustment and reduce provider inquiries.

The Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) are the preferred methods for claim payment communication and payment distribution. Contractors shall promote provider receipt of ERA and EFT.

20.2.5 - Quarterly Provider Update (QPU)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The Quarterly Provider Update (QPU) is a listing of the regulations and program instructions issued by CMS that impact Medicare providers. The QPU is maintained by CMS and available to providers through the CMS website. Providers may elect to join a CMS electronic mailing list, to be notified periodically, of additions to the QPU. Contractors shall promote the existence and usage of the QPU and its electronic mailing list/listserv to their provider community.

20.3 - POE Administration

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall adhere to the following requirements in administering their POE program:

20.3.1 - Provider Service Plan (PSP)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall prepare and submit a PSP annually. The PSP outlines the strategies, projected activities, efforts, and approaches the contractor will use during the forthcoming year to support provider education and communications. The PSP shall address and support all the

implementation strategies and activities stated herein as well as all required activities stated in the yearly Budget Performance Requirements (BPRs).

Contractors shall submit a draft or preliminary PSP for review to their Regional Office (RO) PSP coordinator or contact at the time it submits its annual budget request. Contractors shall send the final PSP electronically by October 31, to their RO PSP coordinator and to CMS Central Office (CO) at ProviderServices@cms.hhs.gov .

Contractors shall adhere to the PSP template/format and instructions located on the CMS website at www.cms.hhs.gov/contractors/providercomm/default.asp when developing and issuing the annual PSP. Contractors shall ensure that they are utilizing the most recent version of the PSP template/format.

20.3.2 - Quarterly Activity Report (QAR)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall prepare and submit QARs on a quarterly basis that address the strategies, activities, and efforts used to support the PCSP. The QAR summarizes and recounts the contractor's provider education and training activities during the previous quarter year. Contractors shall submit their QARs electronically to their Regional Office contact and to ProviderServices@cms.hhs.gov after the end of every quarter in the fiscal year. The deadlines for submitting the quarterly reports are as follows:

First quarter – January 31
Second quarter – April 30
Third quarter – July 31
Fourth quarter – October 31

Contractors shall adhere to the QAR template/format and instructions located on the CMS website at www.cms.hhs.gov/contractors/providercomm/default.asp when developing and issuing their QARs. Contractors shall ensure that they are utilizing the most recent version of the QAR template/format.

20.3.3 - Charging Fees to Providers for Medicare Education and Training Activities

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

CMS expects that contractors shall not charge for the development and presentation of provider education and training and provider education materials. However, there are some circumstances under which contractors may charge fair and reasonable fees to participants to offset or recover costs associated with educational activities.

20.3.3.1 – No Charge

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Except when a provider or external group has requested the training, contractors shall not charge for the development and/or presentation of materials for education and training activities.

20.3.3.2 – Fair and Reasonable Fees

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors may charge fair and reasonable fees in the following instances and/or for the following items to offset or recover the costs associated with the training or educational activity or material; note that fair and reasonable means that the fee charged is in line with the actual cost of the activity or item and is within the means of likely participants.

At a contractor-sponsored training activity, contractors may charge to offset the costs for:

1. Facilities (i.e., costs for rental and set up),
2. Audio/visual equipment (i.e., costs for rental and set up),
3. Light food/refreshments, and
4. Duplication of materials.

Contractors may charge for copies of information available on the contractor's website, including paper or other form (i.e., CD-ROM) sent directly to the provider (i.e., duplication costs, shipping and handling.)

Contractors may charge for costs for development of materials, presentation of materials, duplication of materials, staff time and preparation, travel, accommodations, and registration fees (as appropriate). Please be aware that the contractor may accept nominal speakers' fees or recognition gifts, such as pens engraved with the host logo, coffee mugs, plaques, flowers, etc. However, the contractor is not permitted to accept and/or use substantive gifts or donations associated with participation in education and training activities absent specific authority from CMS.

20.3.3.3 - Considerations and Record Keeping for Fee Collection

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Fees collected in keeping with the above guidance shall be used only to cover the costs of these activities and may not be used to supplement other Medicare contractor activities. Additionally, development and reproduction costs for materials developed expressly for a contractor sponsored training event or workshop and disseminated and used at the event can be included in the costs incurred for that workshop.

Contractors shall keep records per event per fiscal year of the actual costs incurred, i.e., facility rental, audio/visual equipment, light refreshments, development and/or duplication of materials, and all fees charged to, and collected from, registrants. Contractors shall keep records for at least one year from the date of the educational event and shall document actual costs used to support the fees charged.

20.3.3.4 - Excess Revenues from Participant Fees

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Excess revenues from participant fees may occur when the total of the fees collected exceeds the total of the allowable costs. Contractors may use one of the following methodologies for the purpose of determining the treatment and disposition of any excess revenues collected from fee-associated provider education events.

Per event: The total of fees or charges for any event shall not exceed by more than 10 per cent the actual costs incurred for the event. If it does, the contractor shall refund the entire excess amount collected to all the registrants who paid a fee for that event. For example, the contractor may charge participants a $50 registration fee for an event that cost the contractor $10,000 (e.g., light refreshments, meeting facility, and equipment rental), 250 individuals pay to attend and the contractor collects $12,500. Since the amount collected exceeded more than 10 per cent of the costs ($1,000), the entire excess amount collected ($2,500) is disbursed back to all paying registrants.

Per year: The contractor shall total, as of June 30, the fees or charges collected to attend already held fee-associated provider education and training events for the fiscal year. The contractor shall add to that amount total fees or charges the contractor estimates will be collected from attendance at all remaining scheduled events. The contractor shall subtract the total costs (meeting room rental, audio-visual/presentation equipment, light refreshment and food, and specially developed workshop material) from the total of fees collected and estimated for the remaining months of the current fiscal year. If the remainder is a number that is 10 percent or less of total costs, the contractor shall note that amount in the 3rd quarter QAR. If the remainder is a number between 10 and 50 percent of total costs, the contractor shall send a message by July 15 to CMS CO (providerservices@cms.hhs.gov) and the RO PSP representative explaining the amount of excess revenue, and plans for how the contractor will be using this money within the POE program. If the remainder is above 50 percent of the total costs, the contractor shall send a message by July 15 to CMS CO and the RO PSP Coordinator explaining the amount of excess revenue, and be prepared to refund the entire excess revenue equally to everyone who attended any of the contractor's fee-based training events.

20.3.3.5 - Refunds/Credits for Cancellation of Events

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

In order to secure sites needed for future provider/supplier training events, the contractor may have to make commitments under which it will incur contractual expenses for training accommodations and services. The contractor shall make full or partial refunds/credits to providers who register for an event, and cancel before the event, or do not attend the event, within the context of these contractual arrangements. If training is scheduled and the contractor cancels the event, the contractor shall make a full refund to registrants. If there are questions concerning the implementation of this policy in a given case, the contractor shall contact the RO POE coordinator.

20.3.3.6 - Mixed Training Events

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

In situations where provider education and training activities involve both POE and LPET training, the contractor shall allocate the proportional costs between the activities. That is, the proportional share of the cost of a function allocated to POE training is equal to the percentage of time related to this training. For example, if it costs $1,000 to arrange and conduct a mixed training session, with 25 percent of the session related to LPET training, then the proportional cost allocation for the training would be .25 x $1,000 = $250 for LPET training and .75 x $1,000 = $750 for POE training activities. (The Program Integrity Manual, IOM Pub. 100-8, Chapter 1, § 1.4.2.1 and § 1.4.2.3, contains more information about charging fees for LPET training.)

20.3.3.7 - Recording of Training Events

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Entities not employed by CMS, or under contractual arrangement are not permitted to videotape or otherwise record training events for profit-making purposes. If a contractor records a training event, then the contractor may charge a fee for the duplication and mailing of the videotapes upon request.

30 - Provider Contact Center (PCC)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

It is important that all communication be coordinated to ensure consistent responses, due to the various communication channels available to providers today. Medicare contractors shall develop a Provider Contact Center (PCC) offering a range of Medicare expertise to respond to telephone, written (letters, e-mail, fax) and walk-in inquiries. The PCC assures a positive business relationship with Medicare providers through its' responsiveness to provider's verbal and written inquiries. The PCC includes the provider contact center, the general written inquiries unit, and walk-in inquiries staff.

With the exception of technologies discussed in § 30.6.2, CMS is not requiring the use of any specific technologies, as long as the contractor is able to meet all performance standards and requirements in a cost-effective and efficient manner while providing a high level of quality customer service to providers that includes accurate and timely information. To ensure that inquiries receive accurate and timely handling, contractors shall ensure, at a minimum, that contact center staff have readily-accessible information and tools (i.e., access to claims-related information, the contractor's and CMS' Web sites, a computer, and an outbound telephone line).

By October 31st of each fiscal year, each contact center shall appoint a primary provider inquiry contact person (i.e., the contact center manager or other designee) to CMS. The contact's name, business address, telephone number, and e-mail shall be submitted to servicereports@cms.hhs.gov and to the ROs. If the contact person is replaced, the contractor shall submit the new contact information to the service reports mailbox and to the RO within 2 weeks of the change. Contact centers shall also submit a high-level organizational chart for their provider inquiry function to servicereports@cms.hhs.gov and to the RO.

30.1 Inquiry Tracking and Monitoring

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall maintain a tracking and reporting system that identifies at a minimum:

1. The type of inquiry (telephone, letter, e-mail, walk-in, etc.);
2. The person responsible for answering the provider inquiry (by name or other unique identifier);
3. Category of the inquiry (using CMS-provided categories listed in § 90);
4. The disposition of the inquiry, including referral to other PCSP areas or areas elsewhere at the contractor (e.g., appeals, medical review, MSP, etc.); and

5. The timeliness of the response.

Tracking information on referrals to the PRRS shall include details of the inquiry and information about how to reach the provider in case there is a need to clarify the question. Contractors have discretion to determine the additional minimum referral information needed by the PRRS. Data from the tracking system shall be used to analyze the number and types of inquiries in order to generate FAQs to be posted on the Web site, identify areas for telephone CSR training, and identify areas for broader provider education. The tracking system will also be used to generate quarterly reports for CMS use, such as those needed to meet the PSP/QAR reporting requirements.

30.1.1 Provider Inquiry Reporting Standardization

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

CMS requires all contractors to track and report the nature of their inquiry types (reason of the calls) for telephone and written inquiries using categories and subcategories listed according to definitions provided in the CMS Standardized Provider Inquiry Chart, listed in § 90.

These categories are to be used to capture the reason for the inquiry, not the action taken. Contractors may use an additional level of detail, if necessary, to assist in identification of provider education or CSR training needs. However, inquiries reported to CMS, such as in the Quarterly Activity Report, shall use categories and subcategories in the chart.

For all provider general telephone and written inquiries, contractors shall track multiple issues raised by a provider during a single call or in a piece of written correspondence.

30.1.1.1 Required Training

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors' staff working with telephone and written inquiries shall be trained to log their inquiry types according to CMS Standardized Provider Inquiry Chart in the tracking system used by the contractor.

30.1.1.2 Updates to Chart

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall recommend changes to CMS Standardized Provider Inquiry Chart, listed in § 90, including modifications to existing categories and subcategories and new inquiry categories and subcategories. Contractors shall submit changes or comments related to the CMS Standardized Provider Inquiry Chart via the Provider Services mailbox, ProviderServices@cms.hhs.gov. Suggested changes shall include the following information:

- a definition of the inquiry type to be added,
- examples of questions where the inquiry type could be used, and
- information about the number of inquiries associated with it.

The chart will be updated on a quarterly basis, as needed. CMS will define categories to be tracked under the "Temporary Issues Category" and the reporting period for those subcategories through separate instructions.

30.2 - Inquiry Triage Process

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

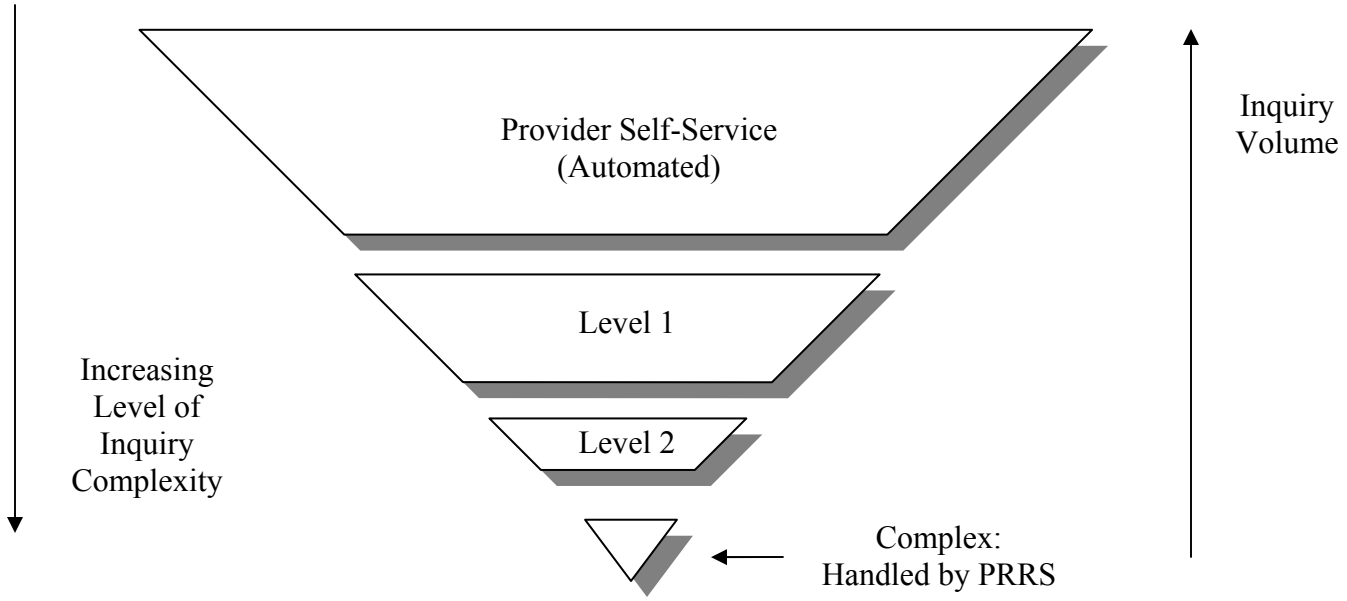
Provider inquiries may require varying degrees of expertise to answer. Using a triage mechanism, the contact center shall be able to route general inquiries within the PCC to the system or person best equipped to respond, with a minimal degree of transfer. The triage procedures shall be used for telephone inquiries, but a contractor may choose to employ a similar mechanism to triage general written inquiries as well. Contractors should develop mechanisms to quickly identify complex written inquiries needing referral to the PRRS. Figure 1 illustrates the levels of complexity and the corresponding provider inquiry volume.

Each contractor shall organize its dedicated provider telephone CSRs into at least two levels to handle questions of varying complexity. Contractors may also choose to specialize CSRs within levels or across contact centers to take full advantage of skill-based routing. Contractors may use technology to route callers to the appropriate level of CSR.

First level CSRs shall answer a wide range of basic questions that cannot be answered by the IVR or other interactive self-service technology. At a minimum, these CSRs shall handle questions that do not require substantial research and can easily be answered during the initial call. They shall have the authority to refer more complex questions to second level CSRs.

Second level CSRs shall have more experience and expertise enabling them to answer more complex questions, including telephone inquiries requiring a higher level of research. Contractors may organize these CSRs in any configuration that best suits the nature of the inquiries received. They may serve as consultant subject matter experts for first level CSRs and, therefore, do not always have to speak directly to a provider. These CSRs may be used to answer first level CSR questions, if the workload demands, and may also handle callbacks. The most complex questions shall be referred to the PRRS, discussed in Section § 30.6.

Figure 1



30.3 – Telephone Services

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall work with CMS, and its designated Telecommunications Technical Support Contractor (TSC) to maintain telephone service for providers. The CMS will use the General Services Administration's telecommunications network contract for its network. All inbound provider telephone service will be handled over the FTS network, with the designated Network Service Provider (NSP). Therefore, contractors shall not maintain their own local inbound lines. Any new numbers and the associated network circuits used to carry these calls shall be acquired via the network.

Contractors shall design their PCC so that inbound inquiries meet CMS performance standards and quality requirements. The design shall optimize the contractor's inbound toll-free circuits so as to ensure the proper ratio of existing FTE CSRs. Contact center customer premise equipment shall not be configured/programmed to return, "soft busies." Contractor contact centers shall only provide "hard" busy signals to the FTS network. At no time, shall any software, gate, vector, application, IVR, and/or ACD/PBX accept the call by providing answer back supervision to the FTS network and then providing a busy signal to the caller and/or dropping the call.

To ensure all inquiries are handled as expeditiously as possible, inbound provider inquiry numbers (and the lines) shall be separate from beneficiary inquiry numbers. Providers shall not use numbers established for beneficiary inquiries.

30.3.1 - Inbound Calls

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The CMS will pay for the rental of inbound T-1/PRI lines and all connect time charges for network services. The costs associated with the installation and monthly fees for these services will be paid by CMS and shall not be considered by contractors in their budget requests. However, contractors shall remain responsible for all other internal telecommunications costs and devices such as agent consoles, handsets, internal wiring and equipment (ACD, IVR, PBX, etc.) and any local or outbound telephone services and line charges. Since these costs are not specifically identified in any cost reports, contractors shall maintain records for all costs associated with providing telephone service to providers (e.g., costs for headsets) and shall provide this information upon request by CMS.

Contractors may choose, but are not required, to publish their general provider telephone number in any appropriate directory listing(s). Contractors shall prominently display their provider customer service number(s) on the contractor's provider Web site, at educational seminars, in newsletters, etc.

30.3.2 - Line Maintenance

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall work with CMS to manage their provider service lines. All change requests associated with the network (e.g., adding or removing channels or T1s/PRIs, office moves, routing changes), shall be processed through the TSC. Contact information for the TSC is located at www.cms.hhs.gov/contractors/customerserv/network.asp. CMS retains the right to initiate changes (i.e., adding or removing lines, reconfiguring trunk groups) as it sees fit based upon an analysis of data and reports.

Contractors requesting a change shall provide CMS an analysis, with supporting data, of their current telephone environment (including a detailed traffic report). This analysis shall be specific to the service being requested and shall demonstrate the need for the requested change. The analysis shall be sent to servicereports@cms.hhs.gov and the appropriate RO. CO will review the request and make a determination based on technical merit and availability of funds. Decisions will be forwarded to the contractor's PCC primary contact, and approved requests will be processed by CMS.

30.3.3 - Troubleshooting Problems

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

To monitor and report a problem, contractors shall follow these steps:

1. Isolate the problem and determine whether it is caused by internal customer premise equipment or the network service.

    - Internal Problem - The contractor's local telecommunications personnel shall resolve those considered a result of an internal problem.

- External or Network Service Problem - Contractors shall report those considered to be a network service problem to the NSP.

2. Involve personnel from the provider TSC, if needed, to answer technical questions or to facilitate discussions with the NSP.

3. File an incident report with the provider TSC for major interruptions of service. Major interruption of service is defined as any incident with a trouble ticket opened for more than 24 hours or a total loss of service. The contractor shall send an e-mail to the service reports mailbox that summarizes the problem and the steps taken to restore full functionality. The contractor shall send a follow-up e-mail to service reports when the problem has been resolved.

4. Use the NSP's Customer Service Center to review documentation, track trouble tickets, or to close a trouble ticket online.

5. File a monthly report with CMS through servicereports@cms.hhs.gov about any interruption(s) of service, copying the affiliated RO.

30.3.4 - Availability Requirements

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall make CSR telephone service available to callers continuously during normal business hours, including lunch and breaks.

Normal business hours for live telephone service are defined as 8:00 a.m. through 4:30 p.m. for all time zones of the geographical area serviced, Monday through Friday. Where contractors provide national coverage or where contractors serve areas outside of the continental United States, CMS will entertain a waiver request for hours of operation. Planned closures during normal business hours shall be approved by CMS CO. Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) by October 31st of the fiscal year about any planned call center closures. This list shall also be sent to the appropriate RO. Changes made to this schedule shall be sent to CMS CO and RO for approval. Call centers shall notify the provider community of the approved closure at least two weeks in advance of closure.

On Federal holidays, in lieu of answering telephone inquiries, contractors may choose to perform other appropriate call center work, e.g., provide CSR training. Contractors shall notify CMS via the service reports mailbox (servicereports@cms.hhs.gov) by October 31st of the fiscal year about any planned call center closures. This list shall also be sent to the appropriate RO. Changes made to this schedule shall be sent to CMS CO using the service reports mailbox and the RO for approval. Call centers shall notify the provider community of the planned closure at least two weeks in advance of closure.

Call center staffing shall be based on the pattern of incoming calls per hour and day of the week, ensuring that adequate coverage of incoming calls throughout each workday is maintained.

In accordance with Section 508 of the Rehabilitation Act of 1973 and the Workforce Investment Act of 1998, all call centers shall provide the ability for deaf, hard of hearing or speech-impaired providers to communicate via Teletypewriter (TTY) equipment. A TTY is a special device

permitting, hard of hearing, or speech-impaired individuals to use the telephone, by allowing them to type messages back and forth to one another instead of talking and listening. (A TTY is required at both ends of the conversation in order to communicate.) Call centers currently having the ability to provide this service for beneficiary callers may use the same equipment, however, they may not use the same inbound lines. Contractors shall follow the process outlined in IOM, Pub. 100-9, Chapter 3, §20.1.1.B to request additional lines to handle this requirement. Contractors shall publicize the TTY line on their websites.

30.3.4.1 - Providing Busy Signals

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contact center customer premise equipment shall not be configured/programmed to return, "soft busies." Contractor contact centers shall only provide "hard" busy signals to the FTS network. At no time, shall any software, gate, vector, application, IVR, and/or ACD/PBX accept the call by providing answer back supervision to the FTS network and then providing a busy signal to the caller and/or dropping the call. The contractor shall optimize their inbound toll-free circuits to ensure the proper ratio of circuits to existing FTEs.

30.3.4.2 - Queue Message

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

When a contact center routes calls to another site, CMS needs to make sure that the contractor handling the calls gets credit for the work. If a call is forwarded over a contractor's system there is no way for CMS to determine the final termination point of the call. Therefore, prior to transferring calls to another center, contractors shall notify the appropriate CMS Regional Office

Contractors shall provide a recorded message that informs callers of any temporary delay while the caller is waiting in queue to speak with an available CSR. They shall use the message to inform the provider to have certain information readily available before speaking with the CSR. The queue message shall also be used to indicate non-peak timeframes for callers to call back when the contact center is less busy.

30.3.4.3 – General Inquiries Line

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The provider toll free numbers installed for FFS claims processing contractors general provider inquiry traffic shall not be used for other applications (e.g., MSP, reviews, EDI, provider enrollment, and other non-claim related provider inquiries) beyond answering general questions for each application. At a minimum, these general lines shall be used to handle questions related to billing, claims, eligibility, and payment. If contractors need new service for other Medicare applications currently being handled on the provider claims inquiry numbers, they shall follow the established process for adding additional toll free numbers. CMS will consider all requests for additional toll free numbers.

The general inquiries line shall answer provider inquiries. Contractors may choose to require other parties without provider numbers, such as consultants, lawyers and manufacturers to submit their inquiries in writing. Call centers should limit the number of issues discussed during

one phone call, but all call centers shall respond to at least three issues before asking the provider to call back.

30.3.5 - Disaster Recovery

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contact centers may be faced with a situation that results in a "major disruption" of service (e.g. an occurrence resulting from an unplanned event or disaster that prohibits the contact center from doing business in a normal manner, including disruption in telephone service electrical service or damage to facilities). For this reason, each contractor shall have plans in place by December 31st of each year that describe how situations will be handled that result in a major disruption of service. These plans shall cover the spectrum of telecommunications capabilities losses (e.g. partial through total loss of operations), and may include arrangements with other contractors to assist in handling the telephone workload. These plans are intended to supplement the contractor's existing disaster or contingency plans.

Plans may be submitted to servicereports@cms.hhs.gov or by postal mail with a copy to the appropriate RO. If the contractor decides to send the plan by postal mail they shall send an e-mail to servicereports@cms.hhs.gov to ascertain the appropriate RO contact.

The contact center shall take the necessary action to ensure that callers are made aware of the situation, and shall take responsibility for activating its own emergency message(s) or re-routing calls. When this is not possible and providers are unable to reach the contact center switch, the contact center shall contact the TSC and request that they initiate a pre-scripted network disaster message(s). Once the problem is resolved, the contact center shall also contact the TSC to de-activate the toll-free network disaster message(s). For all other support requests, provider contact centers shall follow their normal procedures.

30.3.6 - Contractor Guidelines for High Quality Response to Telephone Inquiries

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall have a monitoring program in place to ensure the quality of telephone inquiries responses. That monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the Quality Call Monitoring (QCM) program. The guidelines established apply to contractors' general provider inquiry telephone numbers. The standards shall not apply to those inquiries handled by other units within the contractor (e.g., appeals, fraud, MSP). As contractors are ultimately responsible for the quality of their responses to provider inquiries, contractors shall use the results of their QCM program to identify, and act upon, areas of needed improvement, both for the PCC as a whole and for individual PCC staff. Contractors shall document their monitoring efforts and corrective action plans as applicable, and provide such information to CMS upon request.

A detailed description of each evaluation criteria can be found in the official QCM Scoring Chart. Copies of the QCM scorecard, guide, and chart can be obtained through the QCM database Web site at https://www.qcmscores.com.

30.3.6.1 - Quality Call Monitoring (QCM)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

At a minimum, the contractor's call monitoring program shall ensure that:

1. Calls monitored are from providers and are of the type that the CSR's level typically handles;
2. Calls monitored are sampled randomly so as to be representative of varying days, time of the day, time of the month, and monitors/auditors;
3. Monitoring is done using the official QCM scorecard and chart and recorded in the QCM database;
4. CSR trainees and new CSRs are adequately monitored. However, scores for CSR trainees will be excluded from QCM performance for one 30-day period following the end of their formal classroom training;
5. Monitoring is done in a way that is conducive to the success of the monitoring program;
6. Feedback is provided to CSRs; and,
7. PCC staff are properly educated about the program and its use.

Contractors that tape calls for QCM purposes shall be required to maintain such tapes for an ongoing 90-day period during the year. All tapes shall be clearly identified by date and filed in a manner that will allow for easy selection of tapes for review. Contractors may reuse tapes after the 90-day period. Contractors shall dispose of tapes that are no longer used in a manner that would prohibit someone from obtaining any personally identifiable information on the tapes.

30.3.7 – Calibration

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall participate in all national and regional QCM calibration sessions organized by CMS. (Calibration is a process to help maintain fairness, objectivity and consistency in scoring calls by staff within one or more contact centers or throughout CMS). Contractors with more than one reviewer shall conduct monthly calibration sessions within the contact center. Contractors with more than one contact center shall conduct regular calibration sessions among multiple centers.

30.4 - Written Inquiries

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

All general written inquiries, including letters, faxes, and e-mails, shall be handled consistently for accuracy and timeliness. The contractor shall stamp the cover page of all written inquiries including letters, e-mails and faxes, and the top page of all attachments with the date of receipt in the corporate mailroom and control them until a final answer is sent. Contractors shall not be required to keep the incoming envelope. However, if it is a contractor's normal operating

procedure to keep envelopes with the incoming correspondence, the envelope, incoming letter and the top page of all attachments shall be date-stamped in the corporate mailroom.

30.4.1 – Written Inquiry Storage

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The majority of contractors currently retain all written inquiries on site. Some contractors house files at a remote location during the year due to cost and space constraints. Those contractors housing written inquiries off-site shall notify CMS within 6 weeks of the final BPR date of the exact address/location of their off site written inquiries. This information shall be sent electronically to the servicing RO Provider Branch Chief. This notification is necessary in the event an onsite evaluation review is conducted. Contractors shall allow CMS access to all written inquiries stored off site within 24 hours of notification to the contractor. All written inquiries, whether maintained on site or off-site, shall be clearly identified and filed in a manner that will allow for easy selection for review.

Identification data shall be kept that will allow electronic production of a sequential listing of the universe of written inquiries. In addition, responses shall be kept in a format that allows for easy reproduction. Only necessary and related information shall be kept with each corresponding inquiry.

30.4.2 – Forwarding Misdirected Inquiries

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The contractor shall refer and/or forward written inquiries such as appeals, fraud and abuse, and MSP when appropriate. Documentation shall be kept in the general correspondence unit and shall identify the date the inquiry was referred and/or forwarded and the receiving unit.

30.4.3 – Timeliness

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The 45 business day timeframe begins the day the inquiry is originally received and date-stamped by the contractor and ends the day the contractor sends the response from the mailroom. There may be instances when an inquiry is mistakenly sent to another address used by the contractor. If the contractor has done a proper job of publicizing the correct address to the provider community then the 45 business day timeframe will begin once the inquiry is received in the contractor mailroom where written inquiries are routinely sent. This does not apply to contractors who choose to have all of their mail sent to a separate location and then forwarded to the proper written inquiry unit. For these contractors, the 45 business day timeframe starts the day that the mail is received at the initial location.

In instances where a final response cannot be sent within 45 business days (e.g., inquiry shall be referred to a specialized unit for response), the contractor shall send an interim response acknowledging receipt of the inquiry and the reason for any delay. When possible, inform the provider about how long it will be until a final response will be sent. Interim responses shall

comprise no more than 5% of all written responses. A final response shall be issued within 45 business days of the receipt of information necessary to complete the response.

For those written inquiries that cannot be answered in final within 45 business days, contractors shall issue an interim response within 45 business days explaining the reason for the delay. Acceptable reasons for an interim response include referral to CMS (RO or central office), a shared systems maintainer, or other non-contractor entity. Interim responses shall not comprise more than 5% of all written responses (general responses and PRRS responses). Final responses shall be issued within 5 business days of receipt of the information necessary to complete the response.

If the contractor is responsible for handling both Part A and Part B claims, inquiries requiring response from both of these areas share the same time frame for response (i.e., the 45 business day period starts on the same day for both responses). Therefore, the contractor shall ensure that the inquiry is provided to both responding units as quickly as possible. The response to these inquiries may be combined, or separate, depending on which procedure is most efficient for the contractor's conditions. If a contractor responds separately, each response shall refer to the fact that the other area of inquiry will be responded to separately.

See the chart below for assistance with converting calendar days to business days.

Business Days	Calendar Days
5	7
10	14
15	21
20	28
25	35
30	42
35	49
40	56
45	63

30.4.3.1 – Responding to Written Inquiries by Telephone

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Every contractor shall have the flexibility to respond to provider written inquiries by phone within 45 business days. For tracking and evaluation purposes, the contractor shall develop a report of contact for each telephone response. All reports of contact shall contain the following information:

- Provider's name;
- Telephone number;
- Provider number;
- Date of contact;
- Internal inquiry control number;

- Subject;
- Summary of discussion;
- Status;
- Action required (if any); and
- The name of the correspondent who handled the inquiry.

Upon request, the contractor shall send the provider a copy of the report of contact that results from the phone response. The report of contact shall be retained in the same manner and time frame as the current process for written responses. The contractor shall use its discretion when identifying which written inquiries (i.e., provider correspondence that represents simple questions) can be responded to by phone. If the contractor cannot reach the provider by phone, it is acceptable to leave a message as long as the message does not contain any Protected Health Information (PHI). If after 3 attempts the contractor still has not resolved the inquiry the contractor shall develop a written response within 45 business days from the incoming inquiry; voicemail responses are not acceptable.

30.4.3.2 - E-mail Responses

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

In some cases, an e-mail inquiry received can be responded to by e-mail. Since e-mail represents official correspondence with the public, it is paramount that contractors use sound e-mail practices and proper etiquette when communicating electronically. Contractors shall ensure that e-mail responses utilize the same guidelines that pertain to all written inquiries. Responses that contain financial information, HICN or protected health information shall not be sent by e-mail. If the response shall contain this information, it shall be mailed in hardcopy to the provider or a telephone response shall be given, rather than by e-mail.

30.4.3.3 – Check Off Letters

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Check-off letters are appropriate for routine inquiries like claims status or eligibility. Check-off letters shall not be used to address more complex inquiries. Each check-off letter shall be personalized and completely answer the inquiry.

30.4.3.4 – Contractor Guidelines for Response to Written Inquiries

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall have a monitoring program in place to ensure the quality of written inquiries responses. The monitoring program shall, at a minimum, follow the requirements and performance standards as set forth in the Quality Written Correspondence Monitoring (QWCM) program. The guidelines established apply to contractors' general provider written inquiry responses and PRRS responses. The standards shall not apply to those written inquiries handled by other units within the contractor (e.g., appeals, fraud, MSP). As contractors are ultimately responsible for the quality of their responses to provider inquiries, contractors shall use the results of their QWCM program to identify, and act upon, areas of needed improvement, both for the PCC as a whole and for individual PCC staff. Contractors shall document their monitoring

efforts and corrective action plans as applicable, and provide such information to CMS upon request. Copies of the QWCM scorecard, guide, and chart can be obtained through the QWCM database Web site at https://www.qwcmscores.com.

30.4.3.4.1 Quality Written Correspondence Monitoring (QWCM)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

At a minimum, the contractor's written inquiries monitoring program shall ensure that:

1. Written responses monitored are from providers and of the type that the correspondent typically handles;
2. Written responses monitored are sampled randomly so as to be representative of varying days, time of the day, time of the month, and monitors/auditors;
3. Monitoring scores are recorded using the official QWCM scorecards and charts through the QWCM database (Separate scorecards and scoring criteria are used to evaluate written and telephone responses.);
4. Correspondent trainees and new correspondents are adequately monitored;
5. Monitoring is done in a way that is conducive to the success of the monitoring program;
6. Feedback is provided to correspondents; and,
7. PCC staff are properly educated about the program and its use and each reviewer and correspondent has an up-to-date copy of the scorecard and chart for reference.

30.4.3.4.2 – Calibration

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall participate in all QWCM national calibration sessions organized by CMS. National sessions are held quarterly for each program type so that each program type is calibrated once per quarter, and are rotated between provider and beneficiary inquiries so that each is calibrated twice a year. Contractors with more than one reviewer shall conduct monthly calibration sessions within the written inquiries unit. Contractors with more than one written inquiries unit shall conduct regular calibration sessions among the multiple units.

30.5 - Walk-In Inquiries

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

In the rare circumstance that a provider comes on-site to the contractor to make an inquiry, the contractor shall address the provider's concern(s) and shall count and report the contact as a written inquiry. The contractor shall maintain a log or record of walk-in inquiries. The log, at a minimum shall include the following:

1. Name of inquirer;
2. Time of arrival;
3. Time service was provided;
4. Name of the person handling the inquiry; and,
5. A statement indicating whether the inquiry is closed or still pending.

30.5.1 - Guidelines for Walk-In Service

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The following are guidelines that the contractor shall use for providing high quality walk-in service:

1. After contact with a receptionist, the inquirer shall meet with a service representative;
2. Waiting room accommodations shall provide seating;
3. Inquiries shall be completed during the initial interview to the extent possible;
4. Current Medicare publications shall be available to the provider (upon request); and
5. Contractors shall maintain a log or record of walk-in inquiries during the year.

30.6 - Provider Relations Research Specialists (PRRS)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall maintain PRRS as a joint effort between the PCC and POE units in order to provide consistent, accurate, and timely information to Medicare providers regarding complex inquiries that cannot be answered by the contractor's telephone or written inquiries staff and/or require significant research. Therefore, contractors shall design and staff the PRRS component so that questions beyond the expertise of the CSRs or general written inquiry staff which require more time to adequately research can be answered in a timely and efficient manner. In addition, the PRRS shall also handle complex beneficiary inquiries that cannot be resolved by the Beneficiary Contact Center (BCC) in the MAC environment.

For Contractor Reporting of Operational and Workload Data (CROWD) and Customer Service Assessment and Management System (CSAMS) reporting purposes, if a call is transferred between the two CSR levels, the inquiry shall remain open until it is fully resolved and shall only be counted once. Upon referral of a telephone inquiry to the PRRS, the telephone inquiry shall be closed and a written inquiry is opened.

30.6.1 Complex Provider Inquiries

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Once an inquiry is referred, the PRRS shall take ownership for the inquiry and research and resolve it. The PRRS staff shall respond to the more complex provider questions including those related to coverage policy, coding, and payment policy. Staff shall use the full spectrum of the contractor's resources (i.e., contractor medical directors, contractor Web sites, bulletins, medical review staff, Local Provider Education and Training or LPET staff, claims processing staff), and CMS resources (e.g. Internet-Only Manual, contractor instructions, training packages, Medicare law and regulations, the www.cms.hhs.gov Web site, Medlearn Matters articles, provider specific web pages, and RO staff) when researching answers to complex inquiries.

For those complex inquiries, both telephone and written, that cannot be answered in final within 45 business days, contractors shall issue an interim response within 45 business days explaining

the reason for the delay. Acceptable reasons for an interim response include referral to CMS, a shared systems maintainer, or other non-contractor entity.

The PRRS shall include at least one certified coder to ensure adequate coding expertise although that staff does not have to be assigned exclusively to the PRRS. Durable Medical Equipment Regional Contractors (DME) and DME MACs are exempt from the requirement to have a coding expert staff since the Statistical Analysis DMERC (SADMERC) or the data analysis coding function resolves DME coding questions. The coding questions appropriately answered by the PRRS are those concerning the underlying Medicare payment or coverage policy. Pure coding questions (not related to a Medicare payment or coverage policy) shall be answered with referrals to the correct organizations such as the American Medical Association and the American Hospital Association's Coding Clinic.

PRRS responses shall be considered for provider job aids enabling CSRs to answer similar inquiries in the future. Job aids shall serve as talking points for CSRs. CMS will be increasing the number of national job aids provided to the contact centers. These job aids will be distributed via a contractor-only listserv to all Fee-For-Service (FFS) claims processing contractors. To facilitate this process, contractors shall submit PRRS-generated job aids that are national in scope, to CMS monthly at ProviderServices@cms.hhs.gov. If a contractor does not have any job aids to submit, it shall submit an e-mail simply stating "nothing to submit." CMS will distribute those job aids determined to be applicable nationally via the contractor-only listserv.

30.6.2 - Complex Beneficiary Inquiries

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

In the MAC environment, complex beneficiary inquiries will be referred to the PRRS by the Beneficiary Contact Center (BCC) via the Next Generation Desktop (NGD) and may include telephone, written, and email inquiries. Once an inquiry is referred, the PRRS shall take ownership for the inquiry and research and resolve it. The contractor shall respond directly to the beneficiary and document the response in NGD (See IOM Pub 100-9, Chapter 2, 20.1.10 for NGD technical specifications). Complex inquiries from beneficiaries shall receive the same priority and attention as complex inquiries from providers.

If a response is not provided within 2 business days of receipt of referral, the contractor shall make two attempts to contact the beneficiary by telephone to acknowledge receipt of the complex inquiry and to give an estimated time for resolution of the complex inquiry. All responses shall be completed within 45 business days and may be by telephone or in writing. The contractor shall have adequate language capabilities (English, Spanish, and TTY/TDD) to handle telephone communications with beneficiaries. The contractor shall obtain foreign language support service by contract for other languages. Additionally, the contractor shall fog written responses for reading level (8th grade or less), in accordance with IOM Pub 100-9, Chapter 2, 20.2.1(3.)

The contractor shall provide feedback via the NGD to the BCC identifying inappropriate referrals (routine inquiries that shall have been handled by the BCC) to the PRRS.

30.7 - Provider Contact Center User Group (PCUG)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall ensure that they are represented in the monthly PCUG calls, as they provide a forum for CMS to discuss new and ongoing projects related to telephone customer service. Contact centers may submit topics for consideration in agenda planning to the PCUG mailbox at providerservices@cms.hhs.gov. Further information about the PCUG, including schedules, can be found on the CMS Contractors Page at www.cms.hhs.gov/contractors.

30.8 - Fraud and Abuse

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall ensure that when a provider inquiry or complaint of potential fraud and abuse is received, it is immediately sent, along with a referral package, to the Program Safeguard Contractor (PSC) or Medicare fee-for-service Benefit Integrity Unit (BIU). The referral package shall consist of the following information:

1. Provider name and address;
2. Type of provider involved in the allegation and the perpetrator, if an employee of a provider;
3. Type of service involved in the allegation;
4. Relationship to the provider (e.g., employee or another provider);
5. Place of service;
6. Nature of the allegation(s);
7. Timeframe of the allegation(s);
8. Date of service, procedure code(s);
9. Name and telephone number of the Medicare fee-for-service contractor employee who received the complaint;
10. Beneficiary name who received the service, if known;
11. HIC number of the beneficiary receiving the service, if known; and
12. Date the referral is forwarded to the PSC or BIU.

The Medicare contractor shall keep a record of the cost and workload associated for all provider inquiries of potential fraud and abuse that are referred to the Program Safeguard Contractor (PSC) or Medicare fee-for-service contractor Benefit Integrity Unit using Activity Code 13201 in the Beneficiary Inquiries function.

30.9 – Surveys

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The CMS requires contractors to perform periodic surveys of their customer service operations. The time frame for performing surveys is dependent upon the activity or service to be measured. Examples of areas to be surveyed and/or measured are indicated on the specific notice. Examples include annual contact center technology surveys, staffing profiles, training needs, etc.

40 - PCSP Staff Development and Education

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall be fully responsible for the education, development, evaluation, and management of PCSP staff. This shall be accomplished by contractors providing initial and ongoing education and training of all PCSP staff. In addition, contractors shall have an education and development plan in place and documented for each staff member that addresses the education of new staff and the continued education and development of existing staff. Education and reference materials and tools, as well as policy manuals, shall be made readily available and accessible for all staff.

Contractors shall ensure that educational opportunities are afforded the PCC staff, and that staff are afforded promotion pathways through the design and implementation of the PCC. Contractors may elect to have a small number of provider inquiry staff cross-trained to answer either provider or beneficiary inquiries to assist with disaster recovery or during periods of unusually high inquiry activity. Contractors shall not use such staff on a regular basis, such as to cover the lunch period. It is only permissible to use such staff to assist with beneficiary workload if the provider inquiries performance requirements are being met. Please be aware that MACs will not handle beneficiary inquiries, except by the PRRS.

Contractors shall send training representatives to 2-4 national train-the-trainer conferences provided by CMS. Contractors shall be prepared to send at least one customer service/provider education representative to these training sessions. Contractors shall expect training sessions to run from 2-4 days. This representative shall be responsible for training additional contractor customer service staff. These staff members shall also be prepared to develop training programs for Medicare providers and suppliers on the various initiatives.

40.1 – PCC Staff Development and Training

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The contractor shall train the PCC staff on provider issues and shall equip them with the knowledge and tools to meet CMS' performance requirements for provider inquiries. The PRRS shall be involved in the development of training materials for the general inquiries staff. CMS will also continue to increase and improve the consistent national training information available to CSRs. Training shall be tailored to the tier/degree of specialization of the CSR.

Contractors shall ensure that PCC staff receive both initial and ongoing education and training in order to successfully meet the information needs of providers. Information from the national calibration sessions, as well as regular feedback to CSRs and PRRS regarding their performance, shall be a part of the staff development of the PCC, in addition to the requirements set forth in this manual.

Contractors shall ensure that CSRs are equipped with the tools they need to handle providers' inquiries while meeting the CMS' performance requirements for telephone provider inquiries. These tools, at a minimum, shall include the use of the CMS' Web sites, the contractor's

Medicare provider Web Site, CMS-produced CSR education and reference materials, and CMS-produced provider education materials. Standardized training materials and other educational information will be posted at www.cms.hhs.gov. As such, contractors are encouraged to check this Web site regularly for updates.

40.1.1 - General Requirements

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall provide training for all new CSR hires and refresher training updates for existing personnel. This training shall enable the CSRs to answer the full range of customer service inquiries. The training, at a minimum, shall include technical instructions on Medicare eligibility, coverage benefits, claims processing, Medicare systems and administration, customer service skills and telephone techniques, CSAMS performance requirements, the function of the IVR unit and the use of a computer terminal. Contractors shall have a training evaluation process in place to certify that the trainee is ready to independently handle inquiries.

Upon receipt of CMS developed standardized CSR training materials, including job aids, contractors shall implement these materials for all CSRs on duty and those hired in the future. Since the development of these materials will be done by CMS, it is not expected that there will be any costs to the contractors to use these training materials. Standardized training materials and other training information will be posted to the following Web site: http://www.cms.hhs.gov/contractors/customerserv/train.asp. Contractors shall check this Web site monthly for updated training materials. Contractors may supplement the standard materials with their own materials as long as there is no contradiction of policy or procedures.

All contractors shall train their CSRs about how to find, navigate and fully use their Medicare provider education Web site and www.cms.hhs.gov. CSRs shall be connected to and able to use the contractor's Web site and the CMS Web site for providers.

40.1.2 - Provider Contact Centers Training Program

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The CMS recognizes the need for provider Customer Service Representative training. The goal is to help CSRs improve the consistency and accuracy of their answers to provider questions, to increase their understanding of issues, and to facilitate CSRs' retention of the facts of their training by increasing its frequency. To accomplish this goal, all Medicare Provider Contact Centers may close for up to 8 hours per month for CSR training and/or staff development with the following limitations:

1. The 8 hours approved by CMS for contact center closure shall be used for training time only.
2. The training time shall not be used for corporate meetings.
3. Contractors shall request permission to close according to § 30.3.4 of this chapter.
4. Training time not used within a specific month shall not be carried over to the next month.

Time used for training on Federal holidays is in addition to the 8 hours per month allowed by CMS for CSR training closure. This 8 hour allowance is separate from any training time occurring during Federal holidays.

40.1.3 - Closure Determination

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall perform an analysis to evaluate the appropriate time for closure to anticipate the impact on their ability to meet all CMS performance requirements as instructed in § 30.3.4 of this chapter. Contractors shall consult their POE Advisory Group (§ 20.1.3) about the best hours for training closures and training topics. Blended call centers shall maintain beneficiary telephone service in accordance with IOM Pub 100-9, Chapter 2, when closing the provider telephone lines to train provider CSRs. CMS will not view performance waivers favorably if the training time closures are the justification for poor performance.

40.1.4 - Provider Complaints

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall monitor provider complaints about training time closures and take action to resolve them and decrease the volume of complaints. Reports about provider complaints and their resolution shall be kept on site and available to CMS upon request.

40.1.5 - Training Schedule

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall submit to CMS a training schedule, including dates, times, topics, sub-topics and contact information by the 15th of the month prior to when the training will be performed via the Provider Services mailbox, ProviderServices@cms.hhs.gov using the subject line "Training Schedule". CMS will post training schedules and contact information submitted by all provider Medicare contractors at http://www.cms.hhs.gov/contractors/customerserv/train.asp. Upon receipt of the training schedule, CMS will send an acknowledgement e-mail. Contractors shall assume approval of closures of 4 hours or less unless they receive notification to the contrary.

40.1.6 - Training Closures of More than Four Hours

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

For training of more than four hours on the same day, contractors shall request CMS approval at least a month in advance of the training date via the Provider Services mailbox, ProviderServices@cms.hhs.gov using the subject line "One Time Approval Request". CMS will provide one time authorization for training closure requests of more than four hours. CMS will evaluate this type of authorization on a case by case basis and authorize it under special circumstances within one week of receipt. If the contractor does not receive a confirmation from CMS within one week of submitting its request for training closure, the contractor can close for training under the assumption that its request was approved.

In instances where changes to previously approved training schedules are necessary, contractors shall submit all requests for changes via the Provider Services mailbox, ProviderServices@cms.hhs.gov using the subject line "Change of One Time Approval". A new CMS approval is required to proceed with changes to previously approved training schedules. Changes shall be submitted to CMS within a reasonable time, enough to allow provider notification.

40.1.7 - Provider Notifications

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall notify providers about their closure time for training. At a minimum, contractors shall post a closure notification for providers on their IVRs and websites. Contractors with separate lines for IVR and CSRs shall post a closure notification for providers on both lines. See additional instructions regarding IVR posting in § 50.1 of this chapter. In addition to the IVR and website, contractors shall use their listserv to notify providers of CMS authorized one time only-training closure or a training closure out of the contractor's regular training schedule. Contractors shall use their listserv to notify their provider community of their closure times the first time that they implement the Training Program in their site.

Contractors shall notify providers of all training closures or changes in their training closure schedule at least two weeks in advance of the training date. For training of more than four hours approved by CMS, contractors shall notify providers at least three weeks in advance of training closure.

40.1.8 - CSR Feedback

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

To assure that CSRs are receiving the maximum benefit of the training program, contractors shall use CSRs' feedback from training, CSRs' pre-and post-training and retention results to determine improvement opportunities to their training program and for development of refresher training. Contractors shall implement a process to evaluate the CSRs' progress pre- and post-training on a monthly basis. Also, contractors shall implement a process to evaluate the CSRs' retention of training information on a periodic basis.

40.1.9 – Reports

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall report in CSAMS the following: (1) the number of hours per month that the contractor closed for training during normal business hours and (2) the number of hours used for training on Federal holidays. For additional information on Customer Service Assessment and Management System (CSAMS) reporting requirements, please refer to § 70 of this chapter. Copies of CMS written approval, training schedule, training plan, training materials, as well as CSR attendance sheets, shall be made available upon request.

40.1.10 - CMS Monitoring

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

For monitoring purposes, contractors' telephone systems shall allow calls from CMS or CMS's representatives to CSRs. These CMS callers will not have a provider number.

40.2 - PRRS Staff Training

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Education and training opportunities shall provide PRRS staff with the knowledge and tools to enable them to answer the full range of complex provider inquiries while meeting CMS performance requirements and standards for PRRS. The PRRS will need specialized training in the use of the CMS Internet-Only Manual, the CMS Web sites, the contractor's Web sites, regulation, law, and other information tools to accurately and completely respond to complex provider inquiries, Contractors shall provide these educational opportunities and tools in addition to utilizing CMS-produced PRRS training materials.

50 - Provider Self-Service Technology

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall use self-service and electronic communication technologies as efficient, cost-effective means of disseminating Medicare provider information, education, and assistance. As such, contractors shall take every opportunity to market, educate providers about, and encourage the use of their self-service technologies. At a minimum, such educational opportunities shall include incorporating messages to providers in marketing materials, educational seminars, listserv messages, and instructions on the contractor's Website and IVR.

One important way to successfully manage the provider inquiry workload is to increase and enhance the self-service technology tools available to Medicare providers and to require providers to use these tools when appropriate. Use of self-serve technology enables the provider contact centers to more efficiently handle the increasing volume of provider calls by allowing providers access to certain information without direct personal assistance from contractor staff. Contractors shall offer a variety of self-service options they make available to providers including, but not limited to:

1. Interactive voice response units (IVRs) for telephone inquiries;
2. A PCSP website;
3. Internet-based provider educational offerings; and
4. Use of electronic mailing lists (ListServs).

Contractors shall expand the use of their PSS options and offerings as appropriate, and shall periodically analyze the options they offer, as well as the utilization of such offerings, in order to decide whether and how to expand those offerings.

50.1 - Interactive Voice Response System (IVR)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Although the provider shall have the ability to speak to a CSR during normal contact center operating hours, automated "self-help" tools, such as IVRs, shall also be used by all contractors to assist with handling inquiries. IVR service is intended to assist providers in obtaining answers to various Medicare questions, including those listed below:

1. Claims status;
2. Beneficiary eligibility;
3. Top 100 remittance advice codes issued for each individual contractor (remittance advice codes are reason and remark codes for paid and denied claims);
4. Helpful information to assist providers in resolving issues;
5. Contractor hours of operation for CSR service;
6. General Medicare program information (message duration to be under 30 seconds);
7. Specific information about claims in process and claims completed; and
8. Information that addresses areas of provider confusion as determined by contractors' inquiry and data analyses and prioritization activities.

Contractors shall require providers to use the IVR to access claims status, beneficiary eligibility, and remittance advice notices. Provider telephone CSRs are not intended to answer questions that can be answered through the IVR; they shall refer or transfer the callers to the IVR when such questions arise. Contractors shall identify and contact providers who repeatedly call CSRs for information that is available on the IVR to assist them to effectively use the IVR. At a minimum, such education shall happen at the time of the inquiry to the CSR, but may, in some cases, require post-call reinforcement.

The IVR shall be available to providers 24 hours a day with allowances for normal claims processing and system mainframe availability, as well as for normal IVR and system maintenance. Contractors shall work with their data centers to maximize the availability of the IVR, and shall alert providers when information is not available.

Contractors shall maintain a clear IVR operating guide. Contractors shall market the use of their IVR and the operating guide. Contractors shall print and distribute the IVR operating guide to providers upon request. The guide shall also be posted on the contractor's Web site.

Contact centers shall submit to CMS a call flow document that outlines their IVR scripts and call flow, clearly showing all provider inquiry transactions that they are able to perform through their IVR. Contractors shall also indicate how they are authenticating the call when claims specific information is involved. A copy shall be sent to both the contractor's RO and to the central office (CO) at servicereports@cms.hhs.gov by October 31 each year. If the contractor changes the IVR script, functionality or call flow, they shall submit the revised document to these parties within 2 weeks of implementing the changes.

The contractor IVR shall have the ability to accommodate emergency, time-sensitive adjustments to programmed content as requested by CMS.

50.2 - Provider Education Web Site

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

50.2.1 – General Requirement and Content

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall offer a PCSP website as a provider self-service (PSS) technology to serve as a self-help tool for Medicare providers in gaining information and assistance regarding the Medicare program. This Web site shall be dedicated to furnishing providers with timely, accessible, and understandable Medicare program information. The information contained on this Web site shall be structured in such a way that information is easily found and searchable, so as to reduce the number of pages a user has to go through in order to gain access to the information they are seeking.

To reduce costs, the contractor shall use existing resources and technologies whenever possible. Contractors are ultimately responsible for the structure of their Medicare provider Web site, but are encouraged to design it so that it is clear to providers that they are accessing a provider education Web site for their particular interest (specifically, A/B MAC, Part A, Part B, DMERC, DME MAC, etc.). To maintain the quality of the site, contractors shall ensure that information posted is current and does not duplicate information posted at www.medicare.gov or at www.cms.hhs.gov. Contractors shall strongly consider quarterly review and documentation of such assurance.

Contractors shall consider the use of their Web site for every educational offering they provide to Medicare providers, including approaches such as Web-based conferencing and trainings and computer-based training. However, contractors shall have solutions in place for providers who lack Internet access, such as hosting sites for Web- and computer-based training.

50.2.2 – Webmaster and Attestation Requirements

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall assign a Webmaster responsible for maintaining and updating relevant portions of the contractor's Web site in a timely manner. The Webmaster shall ensure that the Web site complies with CMS' Contractor Web Site Guidelines and Standards located at http://www.cms.hhs.gov/about/web/contractors.asp. Contractors shall periodically review the CMS Contractor Guidelines to determine their continued compliance. Contractors shall send a signed and dated statement from their Webmaster to their RO POE coordinator attesting that their Web site complies with these guidelines.

In addition, during the first three months of the calendar year contractors shall submit an attestation statement indicating whether their Web site(s) adhere to requirements stated in the Publication 100-04, Chapter 23, Subsection 20.7 of the Claims Processing Manual regarding the use of current procedural terminology (CPT) codes and descriptions. This statement shall also be signed by the contractor's Webmaster and sent to their RO PSP coordinator.

50.2.3 – Feedback Mechanism

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall develop and implement a feedback mechanism for users of their web sites. Users shall be able to easily reach the feedback instrument from the provider education Web site. This mechanism shall ask site users for their appraisals of the helpfulness and ease of use of the site and the information contained on it, as well as their thoughts and suggestions for improvement or additions to the site. Any contractor response provided (either via e-mail or postal mail) that is directly related to feedback received related to the format of the website shall not be counted and reported as part of the contractor's provider inquiry workload.

Within their feedback mechanism contractors shall provide information about how providers/suppliers can offer reaction to CMS about contractors' performance in dealings with providers/suppliers. Contractors shall provide the post office mailing address of their CMS Regional Office PSP Coordinator as the referral point for these reactions.

50.2.4 – Contents

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors' PCSP Web sites shall consist of information that is easy to use and easily searchable and shall contain, at a minimum, the following:

1. Provider bulletins or newsletters for the past 2 years;
2. Information concerning joining contractor provider listservs;
3. Frequently Asked Questions (FAQs) based on high volume inquiries (updated at least quarterly);
4. A schedule of upcoming provider education events (e.g., seminars, workshops, fairs);
5. Ability to register for contractor education events;
6. Search engine functionality;
7. A "What's New" or similarly titled section that contains important information that is of an immediate or time sensitive nature;
8. A site map that shows in simple text headings the major components and allows users direct access to these components through selecting and clicking on the titles. This feature shall be accessible from the home page of the web site using the words "Site Map";
9. A tutorial explanation of how to use the web site that is accessible from the home page. The tutorial shall describe how to navigate through the site, how to find information, and explain features. The tutorial information can be on a "help" page as long as the" help" feature is accessible from the home page;
10. Information for providers on electronic claims submission;
11. Information about the contractor, at a minimum including the telephone number(s) for provider inquiries, a fax number(s) for provider inquiries, and a mailing address for provider written inquiries;
12. An IVR operating guide;
13. CMS products, articles and messages posted, as directed; and,
14. A feedback mechanism that asks users for their appraisals of the helpfulness and ease of use of the site, as well as their thoughts and suggestions for improvement or additions to the site;

In addition, the contractor websites shall contain the following links to other web addresses:

1. The CMS Web site at www.cms.hhs.gov;
2. The MLN at www.cms.hhs.gov/medlearn;
3. The site for downloading CMS publications at www.cms.hhs.gov/publications;
4. The site for downloading CMS manuals and transmittals at www.cms.hhs.gov/manuals/transmittals;
5. CMS' Quarterly Provider Update (QPU) Web site page at www.cms.hhs.gov/providerupdate/main.asp;
6. The site that contains descriptions for Remittance Advice reason codes and remark codes at www.wpc-edi.com/servicesreview.asp;
7. CMS' HIPAA Web site at www.cms.hhs.gov/hipaa/hipaa2;
8. CMS' central provider page at www.cms.hhs.gov/providers;
9. CMS' Medicare supplier information site at www.cms.hhs/gov/suppliers;
10. Other CMS Medicare contractors, partners, QIOs, and other sites that may be useful to providers.

50.2.4.1 - Information from CMS

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall receive instructions from CMS to print a provider education article or other information in their provider bulletin or newsletter and also place it on their Web site. Unless specifically directed otherwise, the article or information shall be put on your Web site as soon as possible after receipt, and shall remain on your Web site for 2 months, or until the bulletin or newsletter in which it is appearing is put on your Web site, whichever is later.

50.2.4.2 – FAQs

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

All contractors shall maintain regularly updated FAQs on their Web sites and a link to CMS FAQs. On a quarterly basis, contractors shall submit one or more FAQs appropriate for the national FAQ database. The suggested FAQs shall be submitted on the QARs. National FAQs address issues that are not open to local contractor interpretation. Once CMS has adopted the FAQ nationally and notified the contractor, the contractor shall remove the FAQ answer from its own Web site and link the question to the specific answer on the CMS website. As FAQs are added to the CMS Web site, CMS will notify all contractors using the contractor-only listserv.

50.2.4.3 - Internet-based Provider Educational Offerings

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall offer internet-based provider educational offerings as one source of provider self-service technologies (PSS) that serve as self-help tools for Medicare providers to acquire information about the Medicare program. Contractors shall encourage providers to use the CMS and contractor Web sites for these offerings as well as to sign-up for listservs on both sites so they can learn of them. Web casting, web-based conferencing, and computer-based trainings made available on the contractor website are three possible approaches to expanding Internet use. Contractors shall have at least one Internet educational offering and offer at least one per quarter with a minimum total of 6 events per fiscal year.

50.2.5 - Web Site Promotion

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall actively promote, market and explain their Medicare provider communications Web site and the information and features contained on it. Information about the contractor's Web site shall be part of, or made available at, all contractor provider education and training workshops and seminars, training sessions with individual providers, and all other provider education events a contractor has or participates in.

50.3 - Electronic Mailing List/Listserv

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall offer electronic mailing lists/listservs as one source of provider self-service technologies (PSS) that serve as self-help tools for Medicare providers in gaining information about the Medicare program. These listservs shall notify registrants via e-mail of important, time-sensitive Medicare program information, upcoming provider/supplier communications events, and other announcements necessitating immediate attention. Providers/suppliers shall be able to join electronic mailing lists via contractor provider/supplier education Web sites. Subscribers to the electronic mailing lists shall also be able to unsubscribe via the Web site. Notices shall be published on the Web sites and in bulletins/newsletters that encourage subscription to the electronic mailing lists. Contractors' electronic mailing lists shall be capable of accommodating all of the providers/suppliers it serves. It is recommended that electronic mailing list(s) be constructed for only one-way communication, i.e., from contractors to subscribers.

Contractors shall protect electronic mailing list(s) addresses from unauthorized access or inappropriate usage. Electronic mailing lists, or any portions or information contained therein, shall not be shared, sold or in any way transferred to any other organization or entity. In special or unique circumstances where such a transference or sharing of listserv information to another organization or entity is deemed to be in the best interests of CMS or the Medicare program, the contractor shall first obtain express written permission from its CMS RO POE or PSP Coordinator.

Contractors shall maintain records of their electronic mailing list usage. These records shall include when the electronic mailing list(s) were used, text of the messages sent, the number of subscribers transmitted to per usage, and the author of the message. Records shall be kept for one year from the date of usage.

50.3.1 - Targeted Electronic Mailing Lists/Listservs

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Targeted electronic mailing lists shall be used to send messages and information regarding the Medicare program, policies, or procedures that are of relevance or interest to specific provider audiences. Contractors shall use the following list to determine applicable and appropriate provider/supplier audiences (this list does not preclude the development or use of additional, categorically different or more finite groupings).

Some recommended provider list categories are: Ambulatory Surgical Center, Ambulance, Clinical Diagnostic Laboratory, Community Mental Health Center, Comprehensive Outpatient Rehabilitation Facility, DMEPOS, Federally Qualified Health Center, Hospital, Hospice, Home Health Agencies, Independent Diagnostic Testing Facility, Non-Physician Practitioner, Organ, Procurement, Outpatient Physical Therapy Facility, Physician, Renal Dialysis Facility, Rural Health Clinic, Religious Non-Medical Health Care Institution, and Skilled Nursing Facility.

50.3.2 - Promotion and Membership

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The contractors shall actively market and promote the benefits of being a member of the listserv(s) through the use of all regular provider/supplier communications tools and channels (i.e., bulletins, workshops, education events, advisory group meetings, ACT calls, and written materials.)

For fiscal intermediaries, the total of unique, individual active members of its listserv(s) shall be at 60% or higher of its active provider count. For carriers, the total of unique, individual active members of its listserv(s) shall be at 25% or higher of its active provider count. New Medicare contractors shall have their listserv population at 25% or higher of their active provider count one year after becoming a Medicare contracting entity. For the purpose of calculating this percentage, no one individual member of a contractor's listserv(s) can be counted more than once, and active providers are all individual providers who have had billing activity during the previous 12 months. It is a goal of CMS that listserv(s) populations continually increases. CMS will periodically adjust the percentage requirement in order to accomplish this goal.

60 - Performance Management

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall develop and implement, whenever practicable, effectiveness measures for each education and training activity. This includes, but is not limited to, customer satisfaction survey instruments, pre- and post-testing at workshops and seminars, and other feedback mechanisms. Contractors shall utilize the reporting tools and mechanisms listed below to report workloads, information, and costs associated with their PCSP. Contractors shall keep CMS CO and RO staff current on activities, and issues that emerge, in conducting their PCSP, including invitations to

participate in contractor-sponsored customer service events and activities such as ACTs, POE Advisory Groups, workshops/seminars, Web-based trainings, and teleconferences.

60.1 - Initial Call Resolution

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall handle no less than 90 percent of the calls to completion during the initial contact with a CSR. A call is considered resolved during the initial contact if it does not require a return call by a CSR. This standard will be measured quarterly and will be cumulative for the quarter. All callbacks shall be completed within 5 business days of the original inquiry and documented in the inquiry tracking system, discussed in § 30.1.

60.1.1 - Call Completion

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

1. Each CSR and IVR combined line shall have a completion rate of no less than 80%. This standard will be measured quarterly and will be cumulative for the quarter.
2. Each CSR-only line shall have a completion rate of no less than 80%. This standard will be measured quarterly and will be cumulative for the quarter.
3. Each IVR-only line shall have a completion rate of no less than 95%. This standard will be measured quarterly and will be cumulative for the quarter.

60.1.2 - CSR Identification to Callers

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The CSRs shall identify themselves with at least a first name when answering a call. In order to provide a unique identity for each CSR for accountability purposes, where a number of CSRs have the same first name, it is suggested that the CSRs also use the initial of their surname. If the caller specifically requests that a CSR identify himself/herself, the CSR shall provide both first and last name. Where the personal safety of the CSR is an issue, contact center management shall permit the CSR to use an alias. This alias shall be known for remote monitoring purposes. The CSRs shall also follow the contractor's standard operating procedures for escalating calls to supervisors or managers in situations where warranted.

60.1.3 - Sign-in Policy

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall establish and follow a standard CSR sign-in policy in order for CMS to ensure that data collected for telephone performance measurement are consistent from contractor to contractor. The sign-in policy shall include the following:

1. The CSRs available to answer telephone inquiries shall sign-in to the telephone system to begin data collection;
2. The CSRs shall sign-off the telephone system for breaks, lunch, training, and when performing any other non-telephone inquiry workload. (Note: If the telephone system supports an additional CSR category that accumulates this non-telephone inquiry performance data so that it can be separated and not have any impact on the measurements CMS wants to collect, this category may be utilized in lieu of CSRs signing-off the system); and,
3. The CSRs shall sign-off the telephone system at the end of their workday.

60.1.4 - Equipment Requirements

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

To ensure that inquiries receive accurate and timely handling, contractors shall provide the following equipment:

1. Online access to a computer terminal for each CSR responsible for claims-related inquiries. The computer terminal shall be physically located so that representatives can research data without leaving their desks/seats;
2. Access to the contractor's Web site and www.cms.hhs.gov;
3. An outgoing line for callbacks; and,
4. A supervisory console for monitoring CSRs.

60.1.5 - Remote Monitoring Access

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall provide remote access to their incoming provider inquiries toll free lines. CMS personnel monitoring personnel shall have the capability to monitor provider calls in their entirety by specific workstation (CSR); next call from the network or next call from the CSR queue; and/or specific business line. This will allow CMS personnel to hear calls as they are occurring. The CMS will take reasonable measures to ensure the security of this access, (e.g., passwords will be controlled by one person, and no one outside of CMS service will have access to the passwords).

60.1.6 – Call Acknowledgment

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Calls are acknowledged within 20 seconds by a CSR, IVR, or ACD prompt.

60.1.7 – Average Speed of Answer (ASA)

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Of a calls answered by a CSR during a quarter, the contractor shall maintain an average speed of answer of 40 seconds or less. During the quarter, no month shall have an average speed of answer greater than 60 seconds. This standard shall be measured quarterly and will be cumulative for the quarter.

The ASA standard will be applied to the speed at which the initial call is answered by a CSR. Shall the caller need to be transferred to another level CSR, the time associated with that transfer shall not be included in the ASA calculation.

60.1.8 – Callbacks

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall make 3 attempts to reach a provider for a callback. Callbacks shall be within 5 business days. After 3 attempts, the contractor may send a written response to the inquiry; voicemail responses are not acceptable.

60.1.9 – QCM Performance Standards

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall monitor a minimum of 5 calls per CSR per month using the QCM tool. Of all calls monitored for the quarter, the percent scoring as "Pass" for Adherence to Privacy Act shall be no less than 93 percent. During the quarter, no month shall fall below 85%. This standard will be measured quarterly and will be cumulative for the quarter.

Of all calls monitored for the quarter, the percent scoring as "Yes" for Knowledge Skills shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

Of all calls monitored for the quarter, the percent scoring as "Achieves Expectations" or higher for Customer Skills Assessment shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

60.2 – QWCM Performance Standards

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall evaluate and enter into the QWCM application a minimum of 5 responses per correspondent per month or the entire universe available for monitoring, whichever is less, regardless of how many locations the correspondent is responding for.

Of all written responses monitored for the percent scoring as "Pass" for Adherence to Privacy Act shall be no less than 93 percent. During the quarter, no month shall fall below 85%. This standard will be measured quarterly and will be cumulative for the quarter.

Of all written responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher for Knowledge Skills shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

Of all written responses monitored for the quarter, the percent scoring as "Achieves Expectations" or higher for Customer Skills Assessment shall be no less than 93 percent. During the quarter, no month shall fall below 85 percent. This standard will be measured quarterly and will be cumulative for the quarter.

60.2.1.1 – PRRS

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The PRRS staff shall provide clear, accurate, and complete written answers within 15 business days for at least 75 percent of cases referred by the telephone CSRs, 25 business days for 90 percent of cases referred by the telephone CSRs, and 45 business days for 100% of all cases referred by telephone CSRs or from the general written inquiries area. The business day count begins the day the inquiry was originally received / date stamped by the contractor, either by telephone or in writing, and ends the day the contractor sends the response. Interim responses shall not comprise more than 5% of all general written inquiries and PRRS responses. Final responses shall be issued within 5 business days of receipt of the outstanding information necessary to complete the response.

70 - Customer Service Assessment and Management System (CSAMS) Reporting Requirements

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

The CSAMS is an interactive Web-based software tool used by CMS to collect and display contact center telephone performance data. Each contact center shall enter required telephone customer service data elements into CSAMS between the 1st and 10th of each month for the prior month. To change data after the 10th of the month, users shall inform CO via CSAMS at csams@cms.hhs.gov. In those rare situations where one or more data elements are not available by the 10th of the month, the missing data shall not prevent the contact center from entering all other available data into CSAMS in a timely manner. The contact center shall supply the missing data to CMS within two business days after it becomes available to the contractor. Definitions, calculations and additional information for each of the required telephone customer service data elements as well as associated standards are posted on the CMS' telephone customer service Web site at https://bizapps.cms.hhs.gov/csams. For provider inquiries only, contact centers shall use CSAMS call handling data to improve contact center performance.

70.1 - Definition of Contact Center for CSAMS

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

All contractors shall ensure that monthly CSAMS data are being reported by individual contact centers and that the data are not being consolidated. Telephone performance data shall be reported at the lowest possible physical location in order to address performance concerns. A contact center is defined as a location where a group of CSRs are answering similar type calls (A, B, DMERC, A&B, or some breakout or consolidation of these calls). The physical location could be in the same room, building, or complex but not in a separate geographic location, city, state, etc.

70.2- Data to Be Reported Monthly

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Contractors shall capture and report the following data each month:

Data Reported	Definition
Number of Attempts	This is the total number of calls offered to the provider contact center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/
Number of Failed Attempts	This represents the number of calls unable to access the contact center via the toll-free line. This data shall also be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/
Number of Attempts (TTY/TDD)	This is the total number of calls offered to the TTY/TDD line at the provider contact center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site www.mci.com.
Number of Failed Attempts (TTY/TDD)	This represents the number of calls unable to access the contact center via the TTY/TDD toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI.
Number of Attempts	(for those contact centers with IVR-only lines) - This is the total number of calls offered to the IVR-only line at the provider contact center via the FTS Toll-Free during the month. This shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/
Number of Failed Attempts for those contact centers with IVR-only lines)	This represents the number of calls unable to access the contact center via the IVR-only toll-free line. This data shall be taken from reports produced by FTS toll-free service provider. The current provider is MCI and the reports are available at their Web site https://www.mcicustomercenter.com/
Call Abandonment Rate	This is the percentage of provider calls that abandon from the ACD queue. This shall be reported as calls abandoned up to and including 60 seconds.

Average Speed of Answer	This is the amount of time that all calls waited in queue before being connected to a CSR. It includes ringing, delay recorder(s), and music. This time begins when the caller enters the CSR queue and includes both calls delayed and those answered immediately.
Total Sign-in Time (TSIT)	This is the amount of time the CSRs were available to answer telephone inquiries. This time includes the time that CSRs were plugged-in, logged-in, handling calls, making outgoing calls, in the after call work state or in an available state.
Number of Business days	This is the number of calendar days for the month that the contact center is open and answering telephone inquiries. For reporting purposes, a contact center is considered open for the entire day even if the contact center was closed for a portion of the day and/or not able to answer telephone inquiries for a portion of the day.
Total Talk Time	This is the total amount of time that all CSRs were connected to callers and includes any time the caller is placed on hold by the CSR during the conversation.
Available Time	Available time is the amount of time that CSRs were signed-in on the telephone system waiting for a call to be delivered (i.e., the CSR is not handling calls, making outgoing calls, or in the after call work (ACW) state).
After Call Work Time	This includes the time that CSRs need to complete any administrative work associated with a call after the customer disconnects.
Status of Calls Not Resolved at First Contact	Report as follows: 1. Number of callbacks required. This number is based on calls received for the calendar month and represents the number requiring a callback as of the last workday of the month. 2. Number of callbacks closed within 5 business days. This number is based on calls received for the calendar month and represents the number closed within 5 business days even if a callback is closed within the first 5 business days of the following month.
IVR Handle Rate	For contact centers with combined CSR and IVR lines , this includes: 1. The number of calls offered to the IVR (defined as the total number of calls receiving a prompt offering the use of the IVR during or after business hours); and 2. The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message and did not subsequently transfer to a CSR). For contact centers with separate CSR and IVR lines this includes:

	1. The number of calls offered to the IVR (defined as the total number of IVR-only calls receiving a prompt offering the use of the IVR during or after business hours plus the total number of calls offered to CSRs); and 2. The number of calls handled by the IVR (defined as the number of calls where the caller selected and played at least one informational message).
Calls in CSR queue	This is the total number of calls delivered to the CSR queue.
Calls Answered by CSRs	This represents the total number of calls answered by all CSRs for the month from the CSR queue.
Calls Answered <= 60 Seconds	This represents the total number of calls answered by all CSRs within 60 seconds from the CSR queue.
Quality Call Monitoring (QCM)-Number of CSRs Available for Monitoring	This is the number of CSRs (not FTEs) that take calls on a regular basis, both full-time and part-time CSRs. This number is obtained from the QCM Database.
QCM-Number of Completed Scorecards	This is the number of scorecards that were completed and entered into the QCM database for the month. This number is obtained from the QCM Database.
QCM-Customer Skills Assessment	This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.
QCM-Knowledge Skills Assessment	This is the percent of calls monitored that scored greater than or equal to Achieves Expectations. This number is obtained from the QCM Database.
QCM-Privacy Act	This is the percentage of calls that scored as pass. This number is obtained from the QCM Database.
Training Hours – Normal Business Days	Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training per month. This indicator is used to measure the time the provider contact center is closed during normal business hours for staff development. The number of hours used each month can not exceed 8 hours per month.

Training Hours – Federal Holidays	Report the number of hours (rounded to the nearest half-hour) that the provider contact center closed for CSR training on a Federal holiday(s) per month. This indicator is to measure the time the contact center closed on a Federal Holiday for staff development

80 - Disclosure Desk Reference for Contact centers - Provider Portion

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

IF THE CONTACT IS:	AND:	YOU SHALL:	THEN YOU CAN:	REFERENCE
22. A Provider/Physician Part A or B	Provider/physician inquires about claims information on a pre-claim basis		No claims information may be released on a pre-claim basis without the beneficiary's authorization.	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2
23. A Provider/Physician Part A or B	Provider/physician inquires about claims information on a post-claim basis.	Validate the provider/physician's name and identification number. Verify the beneficiary's: ● Date of Service ● Last name and first initial ● HIC number Items shall match exactly.	Assigned Claims Participating and Non-Participating: Discuss any information on that provider/physician's claim or any other related claim from that provider/physician for that beneficiary. Non-Assigned Claims Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied. General Note: You may speak with the provider/physician about his/her own claims. You may also disclose	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2

IF THE CONTACT IS:	AND:	YOU SHALL:	THEN YOU CAN:	REFERENCE
			information about another provider/physician, as long as both providers/ physicians have a relationship with the beneficiary, and the purpose of the disclosure is to facilitate the payment of the provider/physician that receives the information.	
24. A Provider/physician Part A	Provider/physician inquires about beneficiary eligibility information, which would be available via EDI. This information may only be used in order to submit an accurate claim.	Validate the provider/physician's name and identification number. Verify the beneficiary's: ● Last name & first initial ● Date of birth ● HIC number ● Gender Items shall match exactly.	Release the following eligibility information on a pre-claim or post-claim basis: – Date of death – Lifetime reserve days remaining – Lifetime psychiatric days remaining (if the requesting caller has a psychiatric identification number) – Cross reference HICN – Current and prior A and B entitlements – Spell of illness: hospital full and coinsurance days remaining, SNF full	100-1, Ch. 6, §40 & 60.1

IF THE CONTACT IS:	AND:	YOU SHALL:	THEN YOU CAN:	REFERENCE
			days and coinsurance days remaining, Part A cash deductible remaining to be met, date of earliest billing action for indicated spell of illness – Blood deductible (combined Part A and B) remaining to be met for applicable year entered by provider – Part B trailer year (applicable year based on date entered by provider) – Part B cash deductible – Physical/speech and occupational therapy amount – Hospice data (applicable periods based on the date entered by the provider and the next most recent period) – ESRD indicator – Rep payee indicator – MSP indicator – HMO information: identification code,	

IF THE CONTACT IS:	AND:	YOU SHALL:	THEN YOU CAN:	REFERENCE
			option code, start & termination date – Pap smear screening: risk indicator, professional and technical date – Mammography screening: risk indicator, professional and technical date – Colorectal screening: procedure code, professional and technical date – Pelvic screening: risk indicator and professional date – Pneumococcal pneumonia vaccine (PPV) date – Influenza virus vaccine date – Hepatitis B vaccine date – Home health start and end dates and servicing agency's name.	

IF THE CONTACT IS:	AND:	YOU SHALL:	THEN YOU CAN:	REFERENCE
25. A Provider/Physician Part B	Provider inquires about beneficiary eligibility information, which would be available via EDI. This information may only be used in order to submit an accurate claim.	Validate the provider's name and provider number. Verify the beneficiary's: ● Last name and first initial ● Date of birth ● HIC number ● Gender Items shall match exactly.	Release the following eligibility information on a pre-claim or post-claim basis: – Part A and B entitlement and termination dates – Deductible met (yes or no) for current and prior years – HMO information: "cost" or "risk" plan, effective and termination dates – MSP activity (yes or no) – Home health start and end dates and servicing agency's name. -- Physical/speech and occupational therapy amount	100-1, Ch. 6, §40 & 60.1

IF THE CONTACT IS:	AND:	YOU SHALL:	THEN YOU CAN:	REFERENCE
26. Supplier DMERC	Supplier inquires about claims information on a pre-claim basis.		No claims related information may be released on a pre-claim basis without the beneficiary's authorization.	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2
27. Supplier DMERC	Supplier inquires about claims information on a post-claim basis.	Validate the supplier's name and NSC identification number Verify the beneficiary's: ● Date of service ● Last name and first initial ● HIC number Items shall match exactly.	Assigned Claims Participating and Non-Participating: Discuss any information on that supplier's claim or any other related claim from that supplier for that beneficiary. Non-Assigned Claims Participating and Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied. General Note: You may speak with the supplier about his/her own claims. You may also disclose information about another supplier, as long as both suppliers have a relationship with	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2

			the beneficiary, and the purpose of the disclosure is to facilitate the payment of the supplier that receives the information.	

IF THE CONTACT IS:	AND:	YOU SHALL:	THEN YOU CAN:	REFERENCE
28. Supplier DMERC	Supplier inquires about a Certificate of Medical Necessity (CMN) NO claim has been submitted.		You may not release answers to the question sets on the CMN on file without the beneficiary's authorization.	
29. Supplier DMERC	Supplier inquires about a Certificate of Medical Necessity (CMN) Supplier receives a claim denial due to the CMN. This information may only be used in order to submit an accurate claim.	Validate the supplier's name and NSC identification number. Verify the beneficiary's: ● Date of service ● Last name and first initial ● HIC number ● HCPCs code or name of item Items shall match exactly.	You may confirm whether or not the answers to the question set on the CMN on file matches what the supplier has in his/her records.	
30. Supplier DMERC	Supplier inquires about beneficiary eligibility information, which would be available via EDI. This information may only be used in order to submit an accurate claim.	Validate the supplier's name and NSC identification number. Verify the beneficiary's: ● Last name and first initial ● Date of birth ● HIC number ● Gender Items shall match	Release the following eligibility information on a pre-claim or post-claim basis: – Part A and B entitlement and termination dates – Deductible met (yes or no) for current and prior years – HMO information:	100-1, Ch. 6, §40 & 60.1

		exactly.	“cost” or “risk” plan, effective and termination dates – MSP activity (yes or no) – Home health start and end dates and servicing agency’s name. -- Physical/speech and occupational therapy limit	

IF THE CONTACT IS:	AND:	YOU SHALL:	THEN YOU CAN:	REFERENCE
31. Ambulance Supplier	Supplier inquires about claims information on a pre-claim basis.		No claims related information may be released on a pre-claim basis without the beneficiary's authorization.	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2
32. Ambulance Supplier	Supplier inquires about claims information on a post-claim basis.	Validate the supplier's name and identification number Verify the beneficiary's: ● Date of service ● Last name and first initial ● HIC number Items shall match exactly.	Assigned Claims Participating and Non-Participating: Discuss any information on that supplier's claim or any other related claim from that supplier for that beneficiary. Non-Assigned Claims Participating and Non-Participating: Discuss any information regarding only the claim in question, including why it was reduced or denied. General Note: You may speak with the supplier about his/her own claims. You may also disclose information about another supplier, as long as both suppliers have a relationship with	100-1, Ch. 6, §80 100-9, Ch. 3, §20.2

			the beneficiary, and the purpose of the disclosure is to facilitate the payment of the supplier that receives the information.	

IF THE CONTACT IS:	AND:	YOU SHALL:	THEN YOU CAN:	REFERENCE
33. Ambulance Supplier	Supplier inquires about beneficiary eligibility information, which would be available via EDI. This information may only be used in order to submit an accurate claim.	Validate the supplier's name and identification number. Verify the beneficiary's: ● Last name and first initial ● Date of birth ● HIC number ● Gender Items shall match exactly.	Release the following eligibility information on a pre-claim or post-claim basis: – Part A and B entitlement and termination dates – Deductible met (yes or no) for current and prior years – HMO information: "cost" or "risk" plan, effective and termination dates – MSP activity (yes or no) – Home health start and end dates and servicing agency's name. -- Physical/speech and occupational therapy limit	100-1, Ch. 6, §40 & 60.1

IF THE CONTACT IS:	AND:	YOU SHALL:	THEN YOU CAN:	REFERENCE
34. Billing Service/ Clearinghouse	Billing Service/ Clearinghouse inquires about claims information on a pre-claim basis.		No claims related information may be released on a pre-claim basis without the beneficiary's authorization.	
35. Billing Service/ Clearinghouse	Billing Service/ Clearinghouse inquires about claims information on a post-claim basis.	Validate the employing provider/physician/ supplier's name and identification number. Verify beneficiary's: ● Date of service ● Last name and first initial ● HIC number Items shall match exactly.	You may speak with the billing service/clearinghouse about the employing provider/physician/ supplier's claims.	
36. Billing Service/ Clearinghouse	Billing Service/ Clearinghouse inquires about beneficiary eligibility information, which would be available via EDI. This information may only be used in order to submit an accurate claim.	Validate the employing provider/physician/supplier's name and identification number. Verify the beneficiary's: ● Last name and first initial ● Date of birth ● HIC number ● Gender Items shall match	Release the following eligibility information on a pre-claim or post-claim basis: – Part A and B entitlement and termination dates – Deductible met (yes or no) for current and prior years – HMO information: "cost" or "risk" plan,	

		exactly.	effective and termination dates – MSP activity (yes or no) – Home health start and end dates and servicing agency's name. -- Physical/speech and occupational therapy limit	

80.1 - General Notes and Definitions

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

ASSIGNMENT - When a provider agrees to accept Medicare approved charges as payment in full and the beneficiary agrees to have Medicare's share of the cost of service paid directly to the provider.

BILLING SERVICE - Collects provider/physician/supplier claim information and bills the appropriate insurance companies, including Medicare. It may provide claims billing service only, or provide full financial accounting.

CLEARINGHOUSE - Transfers or moves EDI transactions for a provider/physician/supplier and translates the data into the format required by a health care trading partner, such as a payer. A clearinghouse accepts multiple types of claims and generally other EDI transactions and sends them to various payers, including Medicare. They also accept EDI transactions from payers for routing to and/or reformatting for providers/physicians/suppliers. They perform general and payer-specific edits on claims, and usually handle all of the transactions for a given provider/physician/supplier. Clearinghouses frequently reformat data for various payers and manage acknowledgements and remittance advice. Clearinghouses ordinarily submit initial claims and may qualify as a billing service.

DATE OF SERVICE - the date on which the beneficiary received health services from a provider, physician or supplier. Billing services may view beneficiary or provider data to perform their obligations to the provider/physician/supplier, and if the provider/physician/supplier designates them for that access. To qualify as a billing service, the entity shall submit initial claims on the provider/physician/supplier's behalf.

DISCLOSURE - Releasing information in a Medicare record to anyone other than the subject individual, legal guardian or parent of minor. The individual to whom the information pertains shall authorize (either verbally or in writing) the disclosure of his/her personal information to the third party.

NONASSIGNMENT - When a provider has not agreed to accept Medicare approved charges as payment in full and the claim potentially is payable directly to the Medicare beneficiary.

NONPARTICIPATING - A physician who has not signed a participation agreement and is not obligated to accept assignment on PHYSICIAN Medicare claims; may accept assignment of Medicare claims on a case-by-case basis.

PARTICIPATING - A physician who has signed a participation agreement to accept assignment on all claims submitted to PHYSICIAN Medicare.

PHYSICIAN - Doctor of medicine, doctor of osteopathy (including osteopathic practitioner), doctor of dental surgery or dental medicine (within the limitations in Pub. 100-1, Chapter 5, subsection §70.2), doctor of podiatric medicine (within the limitations in Pub. 100-1, Chapter 5, subsection §70.3), or doctor of optometry (within the limitations of Pub. 100-1, Chapter 5,

subsection §70.5), and, with respect to certain specified treatment, a doctor of chiropractic legally authorized to practice by a State in which he/she performs this function. NOTE: The term physician does not include such practitioners as a Christian Science practitioner or naturopath.

POST-CLAIM - After a provider, physician or supplier services a beneficiary and a claim has been submitted for that beneficiary.

PRE-CLAIM - Before the provider, physician or supplier services a beneficiary and before a claim has been submitted for that beneficiary.

PROVIDER - § 1866(e) of the Social Security Act defines the term "provider of services" (or provider) as: (1) A clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of § 1861(p)(4)(A) (or meets the requirements of such section through the operation of § 1861(g)), or if, in the case of a public health agency, such agency meets the requirements of § 1861(p)(4)(B) (or meets the requirements of such section through the operation of § 1861(g)), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of § 1861(g)) with respect to the furnishing of outpatient occupational therapy services; and (2) A community mental health center (as defined in § 1861(ff) (3) (B)), but only with respect to the furnishing of partial hospitalization services (as described in § 1861(ff) (1)). Definitions of providers, physicians, practitioners, and suppliers, and a description of the requirements that each shall meet in order for their services to be considered covered are described in the following sections.

RELATIONSHIP - When a provider/physician/supplier has rendered, or is rendering, health services to a beneficiary.

REPRESENTATIVE PAYEE - This is a person or organization appointed by the Social Security Administration when it is determined that the beneficiary is unable (due to mental or physical incapability) to handle, manage or direct someone else to manage his/her own benefits, and it is determined to be in the best interest of the beneficiary to appoint a payee. The beneficiary does not have to be declared legally incompetent in order to use a representative payee. However, if a beneficiary is judged legally incompetent, they shall have a payee. The representative payee may make any request or give any notice on behalf of the beneficiary. He/she may give or draw out evidence of information, get information, and receive any notice in connection with a pending claim or asserted rights. The payee has the responsibility to handle all matters related to Social Security and Medicare on behalf of the beneficiary.

SUPPLIER - An entity that is qualified to furnish health services covered by Medicare, other than providers, physicians, and practitioners. The following suppliers shall meet the conditions in order to receive Medicare payment: ambulatory surgical centers (ASCs), independent physical therapists, mammography facilities, DMEPOS suppliers, independent occupational therapists, clinical laboratories, portable X-ray suppliers, dialysis facilities, rural health clinics, and Federally-qualified health centers. A DME supplier is an entity that furnishes DME and has a number assigned by the National Supplier Clearinghouse.

80.2 General Notes

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

Blended contact centers (those that answer both beneficiary and provider calls at the same place) may choose to answer provider calls regarding eligibility inquiries and claims issues on the beneficiary line if they have the ability to track the calls appropriately. Otherwise, they shall refer the contact to the appropriate provider inquiry number.

An individual who makes a request by telephone shall verify his/her identity by providing identifying particulars, which parallel the record to which notification or access is being sought. If the CSR determines that the particulars provided by telephone are insufficient, the requestor will be required to submit the request in writing or in person. Telephone requests will not be accepted where an individual is requesting notification of, or access to, sensitive records such as medical records.

Always remember that access and disclosure involve looking at a Medicare record and giving out information. If you do not have to look at a record (for example, in explaining a letter), access and disclosure rules are not involved. General (that is, non beneficiary-specific) information may be discussed at any time with any caller.

Medicare Customer Service Center (MCSC) employees shall follow the MCSC rules governing disclosure, which require CSRs to obtain at least four items of information to identify the beneficiary for claims information and six items when accessing the MBR or EDB. For consistency among contractors, we recommend that three of those items are the beneficiary's name, HIC number, and date of birth.

On all Medicare Customer Service Center (MCSC) calls dealing with Managed Care issues other than enrollment/disenrollment issues and dates, refer the contact to the Managed Care organization. You may not release any Managed Care claims information. NOTE: Representative payees are not authorized to enroll or disenroll beneficiaries in Managed Care Organizations, unless the representative payee has that authority under State law.

The written authorization shall:

1. Include the beneficiary's name, and HIC;
2. Specify the individual, organizational unit, class of individuals or organizational units who may make the disclosure;
3. Specify the individual, organizational unit, class of individuals or organizational units to which the information may be disclosed;
4. Specify the records, information, or types of information that may be disclosed;

A description of the purpose of the requested use or disclosure (if the beneficiary does not want to provide a statement of the purpose, he/she can describe the use as "at the request of the individual");

5. Indicate whether the authorization is for a one-time disclosure, or give an expiration date or event that relates to the individual or the purpose of the use or disclosure (e.g., for the duration of the beneficiary's enrollment in the health plan);
6. Be signed and dated by the beneficiary or his/her authorized representative. If signed by the representative, a description of the representative's authority to act for the individual shall also be provided; and
    - A statement describing the individual's right to revoke the authorization along with a description of the process to revoke the authorization;
    - A statement describing the inability to condition treatment, payment, enrollment or eligibility for benefits on whether or not the beneficiary signs the authorization;
    - A statement informing the beneficiary that information disclosed pursuant to the authorization may be redisclosed by the recipient and may no longer be protected.
    -

For non-English speaking beneficiaries, you shall obtain the beneficiary's identifying information and verbal consent (via the AT&T language line or similar service, or other interpreter) prior to speaking with the friend, relative, etc.

If the Automated Voice Response (ARU) or Interactive Voice Response (IVR) system obtains the beneficiary's name, HIC number and DOB and one additional piece of information (such as SSN, address, phone number, effective date(s), whether they have Part A and/or Part B coverage) prior to the CSR answering, and this is evident to the CSR, it is not necessary to obtain that information again. The CSR shall ask to whom they are speaking just to ascertain if it is the beneficiary or someone acting on the beneficiary's behalf.

If the ARU or IVR system is not currently programmed to obtain all of the disclosure elements, and it is necessary for the CSR to answer the call, the CSR shall obtain the required data elements before disclosing any identifiable information.

These instructions do not change any requirements for contractors regarding the use of ARU/IVR systems. You are not authorized to reprogram the ARU or IVR at this time.
For situations not specifically addressed here, the CSR shall use his/her discretion, taking care to protect the beneficiary's privacy and confidentiality. Refer situations in which the CSR is unsure of whether or not to release information to his/her supervisor or to the organization's privacy official.

(Rev. 15, Issued: 11-18-05, Effective: 12-19-05, Implementation: 12-19-05)

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Adjustments	Changing the information on a submitted claim to correct an error or the correction of a claim denied in error.	*Cancellation of Claim/Return Claim/Billed in Error*	Contact is asking to cancel a claim that was submitted in error. Includes "services not rendered."
		Claim Processing Error	Contact is asking for an adjustment of an incorrect payment due to a processing error by the local or shared systems, imaging errors, interest not paid or penalties applied in error.
		Claim Information Change	Contact is asking for change or correction of information on a submitted/processed claim; for example, contact asks to add or remove modifiers or procedure codes to correct the amount of units provided, etc.
		Medical Review	Contact is asking about corrections/changes in diagnosis/treatment on processed claim.
		MSP	Contact is asking about the adjustment process for changes in the beneficiary MSP or HMO record.
Administrative Billing Issues	The mechanism and processes of how to bill for Medicare Services, which includes the explanation of CMS instructions, procedures and decision-making criteria for claim review and payment decisions. This does not include an explanation of why a particular claim was denied.	*1500/UB-92 Form*	Contact is asking how to complete the claim form and/or where to find it, including an electronic equivalent of both 1500 and UB92 Forms.
		Advance Beneficiary Notice (ABN)	Contact is asking for general information on ABN, for example, When is it appropriate to use an ABN?, What do I have to do with an ABN?
		Claims Related Reports	Contact is asking for information about accessing and/or receiving reports produced by Medicare regarding to billing trends, history of Medicare payments, comparative billing reports, medical review reports, etc.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Claim Documentation	Contact is asking what information is necessary to submit with a claim to allow processing and/or adjudication of the claim, for example, medical record, progress notes, physicians orders, x-rays, etc.
		Coinsurance	Contact is asking for the amount of coinsurance and/or deductible that a beneficiary shall pay before Medicare begins to pay for covered services and supplies. This subcategory applies to inquiries at a general level. Use "Deductible" subcategory under "Eligibility" for inquiries on annual deductible for a specific beneficiary.
		Fraud and Abuse	Contact is reporting a fraud and abuse allegedly done by a Medicare provider. This subcategory also includes providers calling for guidelines to assure compliance of Medicare rules and regulations against fraudulent and abusive practices.
		Filing/Billing Instructions	Contact is asking for instructions on filing a claim, type of bill necessary for a type of claim, how to correct a claim (adjust a claim), mandatory submission of claims, and time filing limits. Includes inquiries on "How to meet the 72 hr rule for dx services".
		HPSA/PSA	Contact is asking for information about Health Professional Shortage Area (HPSA) and/or Physician Scarcity Area (PSA) classification. This subcategory includes questions such as how to bill based on location class as urban vs. rural area, the use of appropriate modifiers and the amount of bonus payment applicable to them.
Allowed Amount	The amount that Medicare will pay for a certain procedure code according to the Medicare payment systems, fee schedules and locality rates applicable.	*Ambulance Fee Schedule*	Contact is asking for the Ambulance Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Ambulatory Surgical Center	Contact is asking for the Ambulatory Surgical Centers payment amount for a particular item or service provided to a Medicare beneficiary.
		Anesthesia Fee Schedule	Contact is asking for the Anesthesia Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Critical Access Hospitals	Contact is asking for the Critical Access Hospitals payment amount for a particular item or service provided to a Medicare beneficiary.
		Clinical Lab Fee Schedule	Contact is asking for the Clinical Laboratory Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		Drug Average Sales Price (ASP) Resource	Contact is asking about the Medicare Part B Drug Average Sales Price Resource payment amounts. This extensive listing of drugs is a guide. It may not include all drugs that could be considered for payment by Medicare.
		ESRD Composite Rate	Contact is asking for the ESRD Composite Rate payment amount for a particular item or service provided to a Medicare beneficiary.
		Home Health PPS	Contact is asking for the Home Health PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Hospital Inpatient PPS	Contact is asking for the Hospital Inpatient PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Hospital Outpatient PPS	Contact is asking for the Hospital Outpatient PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Hospice Payment System	Contact is asking for the Hospice Payment System payment amount for a particular item or service provided to a Medicare beneficiary.
		Long Term Care Hospital PPS	Contact is asking for the Long Term Care Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Physician Fee Schedule	Contact is asking for the Physician Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.
		DMEPOS Fee Schedule	Contact is asking for the DMEPOS Fee Schedule payment amount for a particular item or service provided to a Medicare beneficiary.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Psychiatric Hospital PPS	Contact is asking for the Psychiatric Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Rehabilitation Hospital PPS	Contact is asking for the Rehabilitation Hospital PPS payment amount for a particular item or service provided to a Medicare beneficiary.
		Skilled Nursing Facility PPS	Contact is asking for the Skilled Nursing Facility PPS payment amount for a particular item or service provided to a Medicare beneficiary.
Appeals	Action initiated by the provider due to disagreement on a Medicare's claim determination.	*Process/Rights*	Contact is asking for general appeal information, appeal process instructions and/or appeal rights.
		Status/Explanation/Resolution	Contact is asking the status of the appeal. This involves whether an appeal has been received and/or whether the time to file an appeal has expired, an explanation of Medicare's determination with respect to the submitted appeal and requests for duplicates of Medicare Redetermination Notices (MRN).
		Qualified Independent Contractor (QIC) Contractor	Contact is asking about an appeal status or information related to appeals reviewed by the QIC.
Claim Denials	Claim that has been fully adjudicated and a non-payment determination has been made based on Medicare rules and regulations.	*ABN*	Contact is asking for clarification on a particular claim denial where the use of ABN applies and the patient is not required to pay the provider for a service.
		Claim Overlap	Contact is asking about claim(s) denied due to an overlap in service dates with a previously processed claim. This may include the denial of a Part B claim for physical therapy services that conflicted with a previously processed inpatient claim with overlapping dates of service.
		Coding Errors/Modifiers	Contact is asking about a claim(s) denied due to an invalid or incorrect code. Includes the absence or incorrect use of a modifier and global surgery denials.
		Contractor Processing Errors	Contact is asking about a claim(s) denied due to a contractor error (incorrect edit, shared systems issue, etc.), when processing the claim.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Contractual Obligation Not Met	Contact is asking about a claim(s) denied because the provider did not comply with their Medicare contractual obligation (for example, the claim was submitted with missing information, the claim was not filed timely, etc).
		CWF Rejects	Contact is asking about a claim(s) denied because information on the claim does not match the CWF beneficiary information (for example, discharge status, name mismatch, female patient with a male procedure claimed). Log under this sub-category CWF issues that need to be corrected through SSA because the provider submitted correct information on the claim and CWF file needs to be updated. Please note that “frequency limit” issues identified by CWF shall be categorized under "frequency limitation" (See below).
		Denial Letter Request	Contact is asking for a copy of the Medicare denial letter, establishing the reason for non payment of services in order to bill another insurer.
		DME POS Issues	Contact is asking about a claim(s) denied due to equipment, item or service not received by a beneficiary or returned to a supplier and other maintenance/services issues. Also, includes inquiries related to invalid CMNs.
		Duplicate	Contact is asking about a claim(s) denied due to same date of service, claim previously processed or paid for the same date and same provider.
		Eligibility	Contact is asking about a claim(s) denied due to incorrect patient information submitted by the provider that does not agree with CWF (for example, incorrect suffix, transposed numbers) and affects the patient's eligibility for Medicare Benefits. Log under this sub-category, issues were there is no need to update information on CWF files.
		Evaluation & Management Services	Contact is asking about a claim(s) where payment was denied or reduced due to a changed E&M code. E&M codes explain how the physician gathered and analyzed patient information, determined a condition and advised the best treatment. Includes services such as: office visits, hospital visits, consultation visits, and care plan oversight.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Frequency Limitation	Contact is asking about a claim(s) that was denied because the allowable number of incidences for that service in a given time period has been exceeded or for a service that was previously billed. Also, includes inquiries related to billing frequency limits for durable medical equipment and supplies such as Capped Rental.
		LCD	Contact is asking about a claim(s) that was denied or reduced based on a local coverage determination (LCD) by the contractor. Coverage determinations reflect the local contractor decision as to whether a product, service, or device is reasonable and necessary.
		Life Time Days Met	Contact is asking about claim(s) denied because a particular benefit is disallowed for a Medicare beneficiary due to the lifetime days limit exhausted.
		Medical Necessity	Contact is asking about a claim(s) denied because the information presented did not indicate services or supplies are reasonable and necessary for the diagnosis and treatment of the illness or injury.
		MSP	Contact is asking about a claim(s) denied due to other insurance existing on the beneficiary file that is primary to Medicare.
		NCD	Contact is asking about a claim(s) that was denied or reduced based on a national coverage determination (NCD) by CMS. Coverage determinations reflect national Medicare coverage policies governing specific medical service, procedure or device.
		Statutory Exclusion	Contact is asking about a claim(s) that items or services were denied by law.
Claim Status	Information about where the claim is in the process and whether it has been paid. Routine claim status questions are to be referred to the IVR.	*Additional Development Request (ADR) Letters*	Contact is asking about a Medicare letter received from the contractor that requests more information or documentation to process pending claim(s). Contact may also be providing a response to a written request.
		Applied to Deductible	Contact is asking about a processed claim where payment was not generated because the payment amount was applied to the beneficiary's annual deductible amount.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		ATP Amount/Check Information	Contact is asking for current Approved to Pay (ATP) amount, current pending claims totals and/or payment information on a claim (i.e., status of check, check number, check amount and issued date).
		Crossover	Contact is asking for information on a claim that is covered by a supplemental insurer, such as Medigap or other private insurance.
		Not on File	Contact is asking for a claim that Medicare does not have on file or that has not been received by the contractor.
		Paid in Error	Contact is asking about a claim that they believe was paid in error.
		Payment Explanation/Calculation	Contact is asking for explanation on how the claim was paid or how the payment amount was calculated. Includes "reimbursement" questions.
		Suspended	Contact is asking about the status of a claim that is pending while waiting for information needed to complete processing.
Coding	Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes or medical procedure codes. Includes the codes, their descriptions, and how to use them.	*CCI Edits*	Contact is asking about Correct Coding Initiative edits that identify types of inappropriate coding combinations, such as comprehensive and component code combinations and code combinations of services or procedures that could not be performed together.
		Condition Codes	Contact is asking about billing codes that indicate whether the claimant meets a condition of the service.
		Procedure Codes	Contact is asking about the numeric representation of a procedure code used to determine reimbursement for services rendered on a claim or for other medical documentation. Includes CPT-4 codes, which belong to the American Medical Association and indicate physician services, physical and occupational therapy services, radiology procedures, clinical laboratory tests, medical diagnostic services, and hearing and vision services. Also, includes HCPCS Codes Level II that determines reimbursement for equipment and medical supplies.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Diagnosis codes	Contact is asking about the numeric representation of a disease, injury, impairment, or other health problem that providers shall use to report the diagnosis for each service and /or item they provide.
		Evaluation & Management Codes (E&M)	Contact is asking about codes that explain how the physician gathered and analyzed patient information, determined a condition, and advised the best treatment. Examples are: care plan oversight, office visits, hospital visits and consultations. E&M codes are a part of the AMA's CPT-4 coding system.
		Modifiers	Contact is asking about two digit codes used in conjunction with a procedure code that provides additional information about the service. The modifier may affect the reimbursement rate of a service.
		MSP Payer/Value Codes	Contact is asking about codes used to designate that another insurer is responsible for full or partial payment where Medicare has no payment or secondary payment responsibility.
		Revenue Codes	Contact is asking about codes that identify specific accommodations or ancillary charges that are provided in a hospital, (e.g., blood, cardiology, radiology, laboratory services, etc.
		Patient Status Codes	Contact is asking about codes that indicate the patient's status as of the "Through" date of the billing period. These codes reflect the destination of the patient not the service received at the ending date. Includes also inquiries related to source of admission codes and discharge status codes.
		Place of Service Codes	Contact is asking about codes on professional claims to identify where the service was rendered.
		Specialty Codes	Contact is asking about codes used on a claim form to indicate a provider's type or medical specialty.
Complaints	An expression of dissatisfaction with service from providers in regards to different aspects of the Medicare operation.	*Contact Center Closure*	Contact is expressing dissatisfaction due to hours of operation or call center closures for CSR training.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Medicare Contractor Operation	Contact is expressing dissatisfaction due to contractor operational errors, procedures, policies, processes, and staff issues not addressed by other subcategories included in this section.
		Medicare Program	Contact is expressing dissatisfaction due to issues with the Medicare program. Includes provider expressions of intentions of leaving the Medicare program.
		Provider Education and Outreach	Contact is expressing dissatisfaction with educational activities, education staff performance or availability of educational resources or activities for Medicare providers.
		Self Service Technology	Contact is expressing dissatisfaction due to content, functionality, instability, formatting and processes related to Provider Self Service tools such as CMS or contractor website, online tools for eligibility inquiries or claim submissions, IVR, etc.
		Staff	Contact is expressing dissatisfaction due to CSR or Staff attitude, incorrect information given or non response to an inquiry.
Direct Data Entry (DDE)	The Direct Data Entry system is an on-line application that allows direct on-line access to Medicare claims, such as: claim entry, error correction, eligibility inquiry, claims status, claim adjustment and roster billing.	*Connectivity/Installment/Processing Issues*	Contact is requesting assistance with the connection, installment, password resets, claim processing and adjustments through DDE.
		Orientation Package	Contact is requesting information or an orientation package related to DDE.
Electronic Data Interchange (EDI)	The system for submitting claims electronically and retrieving Electronic Remittance Advices.	*Connectivity/Installment Issues*	Contact is requesting assistance with the connection, installment and password resets through EDI.
		Front End or Vendor Editing	Contact is requesting information or assistance with errors in the transmission or status of claims submitted electronically.
		Information package/HIPAA Compliant Billing Software	Contact is requesting information or an orientation package related to EDI.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Eligibility/Entitlement	The qualification of an individual to receive Medicare, including various qualifying aspects of Medicare coverage (as described in the associated subcategories). If multiple sub-categories are discussed in the same inquiry, log main category for tracking purposes.	*Beneficiary Demographic*	Contact is asking to verify or update (within the contractor's ability) beneficiary personal information, such as HIC number, address, date of birth, date of death, etc.
		Benefit Days Available	Contact is asking for the number of days in a hospital or SNF that remain available for the beneficiary.
		Deductible	Contact is asking if the beneficiary's annual deductible amount has been met so that Medicare payment for providers' services or supplies can begin.
		HMO Record	Contact is asking whether the beneficiary is enrolled in an HMO, when HMO enrollment began, or for HMO contacts information.
		Hospice	Contact is asking if beneficiary has a hospice record open.
		MSP Record	Contact is asking for information related to other insurance coverage that the beneficiary might have that is primary to Medicare.
		Next Eligible Date	Contact is asking when is the next eligible date for the beneficiary to receive one or more preventive services.
		Part A Entitlement	Contact is asking when the beneficiary became eligible for Part A benefits.
		Part B Entitlement	Contact is asking when the beneficiary became eligible for Part B benefits or whether the beneficiary is eligible for Part B benefits.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
Financial Information	The financial responsibility of providers and/or Medicare. These types of inquiries normally involve the information that comes from the contractor's financial department or requests that are processed by the contractor's financial department.	*Check Copies*	Contact is requesting a copy of a check.
		Cost Report	Contact is asking about the annual report that institutional providers shall submit in order to make proper determination of amounts payable under the Medicare program; for example, How do I submit a cost report? What supporting documents are needed for an acceptable cost report? Have you received my cost report?
		Credit Balance/Account Receivable	Contact is asking about a credit balance that is due to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. Examples of Medicare credit balances instances are: 1) Paid twice for the same service either by Medicare or another insurer; 2) Paid for services planned but not performed or for non-covered services; 3) Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or 4) A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim. Also, includes inquiries to confirm if a payment was applied to an open receivable.
		Do Not Forward (DNF) Initiative	Contact is requesting information about CMS initiative that entails the use of "Return Service Requested" envelopes to preclude the forwarding of Medicare checks and remittance advices to locations other than those recorded on the Medicare provider files, and the provider is not receiving its checks.
		Electronic Fund Transfer	Contact is asking about electronic transfer of Medicare payments directly to a provider's financial institution.
		Offsets	Contact is asking the reason that payment was withheld or for an explanation of the Financial Control Number (FCN#) that appeared on the Remittance Advice.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Overpayment	Contact is asking about the notice that they have received due to Medicare funds in excess of amounts that are due and payable to them under the Medicare statute and regulation. The amount of the overpayment is a debt owed to the U.S. Government.
		Refunds	Contact is asking about a refund, such as, its status, notifying Medicare that a refund is needed, or asking about the process to request it.
		Stop Payment / Check to Be Reissued	Contact is requesting a stop payment, reissuance a check, asking how to request it or verifying the status of a previous request. Also, includes check reissue inquiries due to stale dated checks and checks sent to wrong provider.
General Information	Information that cannot be included in other categories.	*Address /Phone/Fax/Web Address*	Contact is asking for contractor's addresses including website, fax and phone numbers.
		Issue Not Identified/Incomplete Information Provided	Contact failed to explain the reason for the inquiry, or omitted a HIC number or provider number. This sub-category may apply to written correspondence only.
		Misrouted Telephone Call/Written Correspondence	Contact is asking a question that shall be handled in another contractor area, by another contractor and or by another agency/program.
		Reference Resources Referral/Request	Contact is asking where to find or access information about specific topics or requesting information about resources available for provider education or self service options, such as, MEDPARD directory, online claim status availability, electronic remittance advice, IVR, etc.
		Other Issues	Contact is discussing subjects that are not classifiable into the defined categories or subcategories.
HIPAA Privacy/ Privacy Act	The statutory authorities that govern the protections for personally identifiable patient health information and the conditions of its release.	*Authorizations*	Contact is asking for a consent/authorization form or a copy of their patient's authorization, which is necessary to release the information requested.
		Release of Information Request	Contact is requesting a copy of patient history or record.
		Requirements	Contact is asking about the HIPAA Privacy or Privacy Act requirements. Also, includes inquiries related to HIPAA contingency plans and the compliance with HIPPA

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
			transaction rules.
MSP	The term used when Medicare is not responsible for paying primary on a claim that is otherwise the primary responsibility of another payer.	*COB/MSP Rules*	Contact is asking about Coordination of Benefits Rules and/or Medicare Secondary Payer Rules.
		Coordination of Benefits (COB) Contractor	Contact is asking about the COB contractor responsibilities and contact information. Includes situations that require a referral to the COB contractor.
		File Updates	Contact is asking for beneficiary MSP/COB files information or providing information for MSP/COB file update.
		Liens and Liabilities/Settlements	Contact is asking about requesting or accepting a Medicare conditional payment, for services that would otherwise be covered under Workers Compensation, No Fault Insurance, Liability and Group Health Plans (GHP). Also, includes questions about settlement information and the status of a conditional payment.
Policy/ Coverage Rules	Includes inquiries related to policy questions, coverage rules and benefits information.	*Benefits/Exclusions/ Coverage Criteria/Rules*	Contact is asking for clarification of rules and criteria used by Medicare to cover and pay for services furnished to Medicare beneficiaries by Medicare providers.
		Certifications Requirements	Contact is asking about requirements, electronic submissions and/or status, when applicable, of certifications for Medicare Benefits. This may include Hospice certifications and/or Certificate of Medical Necessity.
		Local Coverage Determination (LCD)	Contact is asking about a local coverage policy developed by the Medicare contractor to describe the circumstances for Medicare coverage for a specific medical service, procedure or device within their jurisdiction.
		National Coverage Determination (NCD)	Contact is asking about a national coverage policy developed by the Centers for Medicare & Medicaid Services to describe the circumstances for Medicare coverage for a specific medical service, procedure or device.
		Non-published Items	Contact is asking about the coverage of items with no criteria published by contractor or CMS.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Pre-authorization	Contact is asking about or requesting a pre-authorization for providing Medicare benefits.
		Statutes and Regulations	Contact is asking about the Federal law and regulations that govern the Medicare Program and its operation.
Provider Enrollment	The forms and process by which an individual, institution or organization becomes a provider in the Medicare program, eligible to bill for their services.	*National Provider Identifier*	Contact is asking about the National Provider Identifier (NPI).
		Provider Demographic Information Changes	Contact is asking for verification of their provider demographic information or asking how to request a change/correction of its existing information.
		Provider Eligibility	Contact is asking about his or her status as a Medicare Program participant or not participant provider, and how to change it. Also, includes inquiries related to a provider alert/sanction status period.
		Provider Enrollment Requirements	Contact is asking about the requirements to become a participating provider of the Medicare Program. Also, includes inquiries from a provider not certified by Medicare, overview/orientation of the Provider Enrollment Forms (CMS 855 Form), where to find it and/or instructions on how to complete it.
Provider Outreach	The contractor's educational effort and activities with the provider community.	*Education Referrals*	Contact is requesting contact/visit from Professional Relations Staff to provide supplemental education, discuss an issue in-depth, or to request clarification of a confusing situation.
		Workshop Information	Contact is asking for information about provider outreach activities or educational opportunities for providers and their staff.
Remittance Advice (Remit)	The paper or electronic summary statement for providers, including payment information for one or more beneficiaries.	*Duplicate Remittance Notice*	Contact is asking for a duplicate remittance notice. Includes inquiries where provider did not received his/her remittance notice, needs to send it to the patient's second insurance, needs a single line or a no pay remittance notice.
		ERA Election	Contact is asking for information about how to access and/or receive remittance notices electronically.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		How to read RA	Contact is asking for assistance in reviewing and/or understanding their remittance notice. Includes explanation of the Claim Adjustment Reason Codes and Remittance Advice Remark Codes on the Remittance Notice.
RTP/Unprocessable Claim	A claim(s) with incomplete, invalid, or missing information will be returned to the provider as unprocessable. This action cannot be appealed and the corrected claim(s) needs to be submitted as a new claim. Includes "W Status of Claim" and status of claims to be returned to provider.	*1500 / UB-92 Form Item*	Contact is asking about a claim(s) that was returned because the CMS claim form was not completed with the required information, such as, missing or invalid HICN, name, date of birth or sex. Includes the explanation of narrative of reason codes in the contractor's claims correction file, claims processing system and reports.
		Clinical Laboratory Improvement Act (CLIA)	Contact is asking about a claim(s) that was returned because the claim had a missing or incorrect CLIA number.
		Contractor Error	Contact is asking about a claim(s) that was returned to provider as unprocessable due to a contractor error.
		Contractual Obligation Not Met	Contact is asking about a claim(s) rejected because the provider did not comply with his or her Medicare contractual obligation. For example, the claim was presented with missing information (other than codes or modifiers), the billing was not timely, etc.
		Shared Systems	Contact is asking about a claim(s) that was returned because the patient information on the claim does not match information on CMS's shared systems (FISS, MCS, VMS and CWF).
		Missing/Invalid Codes	Contact is asking about a claim(s) that was returned because of a missing or invalid or changed code. Includes "Invalid CPT" inquiries.
		Place of Service	Contact is asking about a claim(s) that was returned due to invalid place of service or the place of service was not related to the procedure.
		Provider Information	Contact is asking about a claim(s) that was returned due to an incorrect or missing UPIN/NPI.

CMS Standardized Provider Inquiry Chart

Inquiry	Definition	Sub-categories	Definition
		Submitted to Incorrect Program	Contact is asking about a claim(s) that was returned because it was submitted to the incorrect program (FI, Carrier or DMERC).
		Truncated Diagnosis	Contact is asking about a claim(s) that was returned due to incorrect, invalid or missing diagnosis information.
Systems Issues	Medicare electronic systems, including the Medicare Claims Processing Systems and/or customer self-service applications (I.e. CMS website, contractor website, IVR, etc).	*Medicare Claims Processing System Issues*	Contact is presenting situation related to issues with the Medicare Processing Systems; for example, issues due to an aged claim, recycling claim and release of claims, etc.
		Website Issues	Contact is reporting problems with the functionality, stability or use of the CMS and contractor website.
		IVR Issues	Contact is reporting problems with the functionality or use of the contractor's IVR.
Temporary Issues	Includes inquiries that CMS would like to track temporarily due to special circumstances. CMS will provide specific timeframes for the monitoring of temporary issues. For contractor specific temporary issues, please follow instructions on IOM 100-9, Chapter 3, § 20.5.	*Part D Drug Coverage*	Contact is presenting situation related to issues with the implementation of the Part D Medicare Prescription Drug Coverage.
		CERT	Contact is asking information related to the Comprehensive Error Rate Testing (CERT) Program.